Iowa Department of Human Services

State Innovation Model Grant Operational Plan – Award Year 3

March 24, 2017 Submission

Contents

Section A: Executive Summary

1. Summary of Model Test

The three-part aim of *"Healthier Communities, Better Care, and Smarter Spending"* is the national model of health care transformation. It recognizes that for a value-based reimbursement system to be successful and sustainable, it will require focus on prevention and efficiency as well as diagnosis and treatment. The three-part aim aligns providers, payers, and their communities into a common task of population health.

The resources provided through the Iowa SIM grant will be used to align and transform Iowa's statewide delivery system to one focused on population health. Our vision is that **Iowans experience better health and have access to accountable and affordable healthcare in every community**. Through the SIM program, Iowa will focus on two primary drivers; Aligning payers in value based purchasing (VBP) that effectively moves the healthcare system from volume to value and equipping providers to engage in population health needs and focus on value outcomes. Together, these approaches ensure a robust, statewide healthcare transformation to achieve Iowa's end state vision, for a post-SIM environment where providers are paid on value outcomes and communities and health systems work together to produce healthier people in a system that is affordable and sustainable.

Specifically, the Iowa test is advancing an ACO strategy across payers immediately, and building toward an Other Payer Advanced APM (OP AAPM) determination to enable Iowa ACO provider groups the ability to achieve the Qualified Participant (QP) status in reporting year 2019 and beyond. As noted in the Operational Plan sections below, there is VBP contracting at varying levels of financial risk in Iowa today. As the Medicaid agency pursues alignment in contracting between the MCOs and ACOs, we will increase financial risk levels, increase covered lives and incorporate clinical data into the quality definition. The state believes these efforts will reduce healthcare costs while also improving quality.

The Iowa test is spending an equal effort on delivery system reform so that care delivery is improved and providers focus on population health strategies. The Iowa care model equips and supports providers engaged in value-based care by providing tools that enable better care delivery and technical assistance to implement the tools. The state has a strong foundation of primary care and is well educated on the Patient Centered Medical Home (PCMH) model. Because of the strong adoption of PCMH in Iowa, we can focus our SIM delivery system reform efforts on tools that integrating population health strategies and a better use community resources that recognize social determinant data that impact individual health outcomes.

The Iowa SIM is testing if targeted care delivery improvement linked to value-based payment reform will improve population health and is a sustainable approach.

Iowa SIM Goals by 2019:

Hypothesis: Healthcare costs are reduced while quality is improved with value based payment models by:

- Provider participation and covered lives participation in value-based purchasing reaches 50% in Iowa.

- Iowa has received approval of at least one “Other Payer Advanced APM” program
- Reduce the Total Cost of Care for Wellmark and Medicaid population by 15% below projected targets.

Hypothesis: Patients are empowered and supported to be healthier by:

- Reduced rate of potentially preventable readmissions in Iowa by 12%
- Reduced rate of potentially preventable ED visits in Iowa by 20%
- Reduced rate of Hospital Acquired Conditions by a 20% reduction in Clostridium Difficile and All Cause Harm
- Iowa increases the number of provider organizations financially successful in Alternative Payment contracts from the 2015 baselines (those that share in savings and incentives for each payer)

Iowa SIM Goals for AY3:

Hypothesis: Healthcare costs are reduced while quality is improved with value based payment models by:

- Provider participation and covered lives participation in value-based purchasing reaches 45% in Iowa.
- Reduce the Total Cost of Care for Wellmark and Medicaid population by 8% below projected targets.

Hypothesis: Patients are empowered and supported to be healthier by:

- Reduced rate of potentially preventable readmissions in Iowa by 6%
- Reduced rate of potentially preventable ED visits in Iowa by 10%
- Reduced rate of Hospital Acquired Conditions by a 10% reduction in Clostridium Difficile and All Cause Harm
- Iowa increases the number of provider organizations financially successful in Alternative Payment contracts from the 2015 baselines (those that share in savings and incentives for each payer)
    - Baseline: Wellmark - 11/13 received shared savings, Medicaid - 5/5 received incentives, and Medicare - overall 23% percent of ACOs in the Midwest received shared savings.
    - Refer to Figure 1 for more detail on this measure and target tracking overtime.

Achieving these goals and targets will lead to true transformation in Iowa that carries beyond the two remaining SIM grant years.
This is outlined in Figure 1: Goal Projects and Impacts

Background:

Iowa started our SIM R2 Test proposal with the intent to implement an ACO model in the Medicaid population that aligned with Medicare’s ACO programs and Wellmark BCBS of Iowa’s ACO programs. Both Wellmark and Medicare have been conducting ACO activity at various levels of risk in Iowa since 2012. Medicaid, with a similar focus, began to introduce ACO concepts in 2014 with the expansion population (Wellness Plan, 0-100% FPL). Together, Medicare, Medicaid, and Wellmark cover 90% of Iowans. In 2015, Medicaid reported 44% of

Primary Care providers participated in a Medicaid VBP program. Wellmark reported 53% of their primary care providers engaged in VBP.

In January of 2015, the Governor announced the strategic shift to modernize Medicaid and move to a full Managed Care model starting January 2016. This strategic shift in Medicaid changed a few of the secondary drivers and actions in our SIM Operational Plan from the original proposal, but does not change the SIM vision or overarching aims to Improve Population Health, Transform Healthcare, and Promote Sustainability. As stated by DHS Director Palmer, "The shift to managed care is not the end game, but the means to the end that supports and aligns with the state's vision and commitment of a healthier Iowa." Medicaid is still committed to the original SIM aims and will leverage the partnership with the new MCOs to carry out and achieve our goals by aligning the MCOs to engage in ACO contracting with the delivery system.

Also in 2015, CMS announced MACRA legislation that dramatically changes how Medicare providers are paid and how this legislation is a driver to advance the goals set forth by Secretary Burwell, to move from volume to value-based payment arrangements.

Although the above two events occurring during the first Award Year of Iowa's SIM grant are significant, they are also complimentary to Iowa's SIM efforts of moving our delivery and payment structures to value driven programs.

Accomplishments To-date:

- Reconciled the original Iowa State Innovation Model (SIM) proposal with implementation of the Governor's new, comprehensive Medicaid Managed Care (MCO) Strategy
- Ensured key, strategic SIM project concepts were incorporated into Iowa's final revision of the managed care RFP such as including Value Index Score (VIS) and Total Cost of Care (TCOC) into the MCO's contract, as well as, the goal for each plan to reach 40% of their covered lives in a Value Based Purchasing (VBP) arrangement
- Successfully launched Medicaid Managed care April 1st, 2016
- Held four successful, well attended Statewide SIM Learning Events, with key speakers like Governor Terry Branstad and Dr. Steven Cha
- Leverage HIT to successfully launch the Statewide Alert Notification (SWAN) system to providers engaged in Medicaid VBP. The system averages 2,000 Medicaid alerts every month and provides real-time Health IT that improves health outcomes while improving how care is delivered
- Successfully released RFP, reviewed and awarded six Community Care Coalition (C3) systems, covering 20 counties, to organize and support community-based resources to help improve population health outcomes
- Developed infrastructure to support a database and dashboard for C3 communities to promote rapid cycle improvement
- Refreshed the VIS online dashboard 8 times during year one, 4 times during year 2 offering specific quality tracking metrics to inform providers and track progress necessary for VBP.
- Delivered provider-specific 2016 VIS baseline scores to support providers and MCOs in VBP programs

- Completed the state's community needs assessment and health improvement plan (CHNA/HIP). CHNA data entered into a newly created database that can be queried to determine what counties identify diabetes, tobacco and obesity as needs, and what social determinants of health were identified by the counties.
- Substantial stakeholder work conducted throughout SIM, guided by a stakeholder engagement plan. Key success in this area is seen by continued engagement between Medicaid and Wellmark, high attendance to SIM Learning Events by provider and community groups, and continued engagement by state leadership.
- The definition of the Strategic Implementation team and the development of an Innovation and Visioning Roundtable represent a framework for sustainable transformation in a post SIM environment.

Challenges To-Date:

- Introduction of Managed Care during Award Year 1 led to many mid-course clarifications, specifically:
    - Time spent during AY1 reconciling the original Medicaid approach to contracting with ACOs directly to the introduction of Managed Care Organizations
    - The collection of and reporting of VIS quality measures and Total Cost of Care to inform VBP and the use of this tool by the MCOs
    - The announcement of MCO delayed start moving from January 1, 2016 to eventually April 1, 2016 caused Medicaid to address a gap of programing during the delay. For example ACO VBP contracts, the PCCM programs known as MediPASS and Iowa Wellness Plans , the statewide MBHO carve out known as the Iowa Plan, were all terminated on 12/31/2015, leaving the Medicaid FFS program to make quick modifications to cover services until April 1, 2016
    - The introduction of managed care contracting disrupted providers engaged in value-based contracts in Medicaid. More attention in 2016 was spent on MCO network adequacy and paying FFS claims, than urging MCOs to advance ACO value-based contracts
- For Medicaid, the analytics around dual eligible data (the collection of and use of Medicare Part A and B data) to inform a Total Cost of Care calculation has been challenging. The use of this data is a necessary step in integrating the Long Term Care population into a VBP program. The steps to access the data from CMS, delays within Medicaid to stage the data, and then finally with the analytic vendor to process and incorporate the data has primarily challenged Iowa to meet the goal to incorporate LTSS in the 2017 VBP program. A new milestone to baseline and integrate LTSS in the 2019 VBP program has been purposed.
- The SWAN system although successfully launched and functioning had to contemplate the new role of MCOs and Medicaid in the new environment. This has led to a quick mid-course correction in how ACO and MCO programs identify their Medicaid members and who should receive alerts. The SWAN system paused real time alerts on September 15, 2016, and then issued updated participation agreements and informational letters describing the new process on October 27, 2016. The DHS sent out 132 letters to Medicaid members alerting of potential data sharing breaches on November 10, 2016 to ensure compliance with HIPAA.
- The Introduction of MACRA during the SIM grant and the final rules released in October caused Iowa to pause to review and vet the impact and opportunities. This led to many

hours in developing an Iowa SIM Year 3 approach that is aligned and complementary to the goals of CMS. Although the final rules were just recently released, they were released with a comment period and notably some areas are still left undefined, specifically around the process a state will take to designate a program as an Advanced APM.

- A challenge is linking identification of the social determinants of health to reforming the delivery and payment systems. Iowa's health and healthcare providers are more aware than ever that where we live, work, and play determines our experience of health and quality of life. Kate Breslin of the Schuyler Center for Analysis and Advocacy shared her thoughts about this connection in her 2016 presentation.[1] She states, "There is growing recognition of the FACT that the vast majority of premature mortality and morbidity is attributable to social, behavioral, and environmental factors yet the US spends most health-related money on health care, not the social determinants." (Breslin, 2016). She connects to a statement from the New York VBP Roadmap identifying the importance of social determinants of health in payment reform, "the framework for value-based payment will maximally incentivize providers to focus on the core underlying drivers of poor health outcomes- whether traditionally in the medical realm or not."[2] (New York State Department of Health, 2015). To capture the data necessary to provide care coordination for social needs to improve outcomes, clinicians and health systems will need to agree on how to collect this data, how to analyze it at the individual and community level, and identify the appropriate interventions that link the patient to necessary community resources. This will represent changes in work flow and philosophy that could potentially overwhelm the system without first building consensus and adopting aligned strategies.

These accomplishments and challenges highlight Iowa's ability to execute on a plan as well as the ability to be flexible and pivot to meet the needs of the current environment. Discussions with CMMI have led Iowa to confirm our current payment reform program (ACOs) aligns with the overarching HHS goal to increase payments linked to quality and to further pursue approaches that align with the Quality Payment Program (like the A-APMs through an Alignment Track). Iowa is vetting new opportunities presented by CMMI around All Payer approaches (Transformation Track). We recognize these two approaches can help increase value-based care models within Iowa. If there is a common vision with SIM and a path outlined for Iowa, we can pursue both tracks to fully realize transformation in Iowa beyond our SIM grant funding. Alignment of ACO models is part of the SIM model test. An All Payer model could complement our SIM test and further advance transformation past the SIM model test years.

Iowa Social Determinant Focus Areas:

Within this Operational Plan, Iowa has included approaches to expanding interactions based on the social determinants within the domains of screening, disease-specific interventions, community resource utilization, collaborative partnerships, analysis of existing data, exploring new data collection opportunities, and supporting communication loops that assist in community-based/ population applied interventions. More specifically, Iowa has identified six

[1] Breslin, K. (2016, June 2). *Social determinants of health and Medicaid payment reform: Community integration leadership institute.* Retrieved from http://nyrehab.org/images/Kate_Breslin_PPT.pdf

[2] New York State Department of Health. Medicaid Redesign Team. (2015, June 2015). *A path toward value based payment: New York state roadmap for Medicaid payment reform. Retrieved from https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/vbp_roadmap_final.pdf*

focus areas to address within activities related to expanded use of a health risk assessment. Those areas are:

- Health and health care access
- Food insecurity
- Supportive housing
- Education and literacy
- Social support
- Transportation

As described throughout this report, this is an area of both challenge and opportunity for Iowa. While multiple stakeholders would benefit from the data produced by aggregating individual responses to questions in these categories, the infrastructure necessary to support this important process is currently limited. Data collection currently occurs but is sporadic at best and the coordination among key partners to use the information for planning and intervention is nominal. Iowa's SIM project proposes implementation of a core substructure that will expand the capacity for providers, health systems, public health agencies, statewide organizations, and communities to collectively promote interventions being piloted by the Community Care teams and other stakeholders that will minimize the impact of the social determinants on health.

2. End State Vision

Transformation in the Iowa health care system requires a broad vision and is certainly a complicated task. It will require alignment of new partners who in the past have been competitors. It can be best understood as an operationalized change-processes sustained through an underlying payment reform increasingly aimed at quality. As such, the project will reach beyond the grant period itself. The grant provides vital, early support necessary to organize leadership, define the vision, engage key stakeholders, implement programs, and attain enough critical mass so that transformation is inevitable because the healthcare marketplace has been re-defined. Through the SIM grant, Iowa is building a platform of systems and policies that will be mature enough to move and grow even after the SIM funding support falls away.

In the post SIM environment, enough providers, payers and members engage in a value-based health system, so that by the year 2021 at least 80% of payments to healthcare providers are firmly linked to quality. The payment models both support and incentivize providers toward value (cost and quality). Providers and Payers use HIT transparently, in partnership to improve outcomes.

In the post SIM environment, payers, providers, communities and government agencies recognize that "healthcare" is inclusive of the broader definition of health; considerations of healthcare will include supporting services and activities that focus on keeping people well, lowering healthcare risk and the prevalence of chronic disease more than responding to unmanaged crisis. Providers have access to and the ability to use HIT data that support these broader health activities.

In the post SIM environment, providers use HIT data effectively to make better care decisions, target risk within their assigned population, take action during transitions of care, and follow-up

on clinical and social care referrals. The data (and ideally, payment risk) spreads beyond traditional clinic walls to key aligned partners in the community helping to better address social determinants factors that are so critical to health outcomes.

In a post SIM environment, Iowans have robust healthcare coverage and access to services is readily available no matter where you live (urban or rural), but at the same time transformation efforts demanding better value influence that total costs come back in line with overall economic marketplace.

Figure 1: Goals Projection and Impacts

	Baseline	Award Year 3	End of Award Year 4	Post SIM Environment
Goal		Providers and Covered lives in VBP increases to 45%	Providers and Covered lives in VBP increase to 50%	Providers and Covered lives in VBP increases to 80%
Impact	In 2015, 10.9% of Medicaid and 32% of Wellmark lives were covered under VBP programs. Additionally, 44.7% of Medicaid primary care and 53% of Wellmark primary care participated in ACO programs.	While provider participation is already close to 45% in Medicaid and over 45% in Wellmark, increasing the number of covered lives under those existing contracts to reach 45% will motivate providers to prioritize process improvements to achieve success in these arrangements	Additional increases in financial risk categories within VBP (3B) will intensify provider's attention to achieving shared savings outcomes. Getting Medicare, Wellmark and Medicaid to 50% of covered lives aligns payment reform and delivery system reform efforts.	Value based care like ACO contracting is what providers have embraced in Iowa. They focus on population health strategies and engage in public health prevention because the expectation of a more quality oriented, consumer-driven marketplace has changed; this is necessary to remain competitive and viable.
Goal		Iowa receives approval of at least one "Other Payer Advanced APM Program		
Impact	In 2015, the MACRA legislation regarding Other Payer Advanced APM was not released; however, Iowa providers were participating with Medicare, Medicaid and Wellmark in APM programs, known as ACOs.	Iowa stakeholders realize the importance of Medicaid and Wellmark pursuit of an A-APM designation. Discussions around the clinical quality measures and the means at which those measures are collected and incorporated in an ACO contract are vetted. Medicaid works in partnership with the MCOs to implement an aligned program that meets the requirements of A-APM	The ACO programs for Medicaid and Wellmark are reviewed with CMMI and a designation is achieved. Providers are increasing covered lives under each ACO A-APM program and have a path to be a Qualified Participant in the QPP program in 2019 and beyond	Iowa providers have positioned themselves to transform into a system that is focused on value. They have the tools and supports necessary to thrive in payment models with all payers in Iowa.

	Baseline	Award Year 3	End of Award Year 4	Post SIM Environment
Goal		TCOC Reduced by 8% below expected (Medicaid and Wellmark)	TCOC Reduced by 15% below expected (Medicaid and Wellmark)	TCOC has come back in line with overall economic marketplace in Iowa. Healthcare is affordable for Iowans.
Impact	In 2015, the Medicaid TCOC population based, per member per month was $362.46 Additionally each year, Medicaid and Wellmark will calculate a TCOC PMPM for members in VBP, using a 3M risk adjustment and TCOC methodology, establish an expected rate and set a budget for ACOs.	More providers have successful VBP contract results, allowing them to continue to seek ways to transform healthcare.	More providers have successful VBP contract results, allowing them to continue to seek ways to transform the healthcare system.	Healthcare cost trends have reversed in Iowa in both urban and rural environments. Because preventable events have reduced and the system is no longer built upon these unnecessary cost drivers, the system has refocused on preventions and supporting services and activities that keep people well – like the dental delivery system already does for oral health today, for those with coverage.
Goal		Reduce Potentially Preventable Emergency Visits (PPV) by 6% Readmissions (PPR) by 10%, and Hospital Acquired Conditions (HAC)	Reduce Potentially Preventable Emergency Visits (PPV)by 12% Readmissions (PPR) by 20%, and Hospital Acquired Conditions (HAC)	Payers, Providers, communities, government agencies recognize “healthcare” is inclusive of the broader definition of health
Impact	Medicaid PPV = 71.14% Medicaid PPR = 6.28% Iowa c.Diff = .058%	Providers find success in using new tools that drive efficiencies in the system. A new focus on care coordination and preventing unnecessary events emerges	In addition to lower preventable events, TCOC is reduced and providers are successful in ACO contracting. They continue to see ways to use data and improve clinical and social care referrals to support value driven systems.	Because preventable events have reduced and the system is no longer built upon these unnecessary cost drivers, the system has refocused on preventions and supporting services and activities that keep people well.

	Baseline	Award Year 3	End of Award Year 4	Post SIM Environment
Goal	Iowa Providers increase success in APM (risk-based) payment models			
Impact	In 2015, Wellmark had 11 out of 13 organizations successful in an APM. In Medicaid there were 5 out of 5. Medicare reports 23% of ACOs in the Midwest were successful in shared saving programs.	As more and more Iowa providers find success in transforming their system to value-drive (not volume-driven), other provider groups enter APM programs	More provider groups engage in APMs and continue to see ways to use data and improve clinical and social care referrals to support value driven systems.	The system has refocused on preventions and supporting services and activities that keep people well. Iowa's healthcare economy has stabilized.

3. Driver Diagram

The 2017 Driver Diagram has been reformatted and modified to better reflect the work of Iowa. Changes include:

- Reworked the Iowa Vision statement
- Added a Healthcare Innovation and Vision Roundtable to the diagram representing the engagement and efforts of transformation occurring in Iowa
- Removed Population Health Improvement Plan as a Primary Driver and repositioned it as a cross cutting activity. Population Health strategies are embedded in each driver.
- Added Health IT Enhancements and Quality Measurement as cross cutting activities. Quality Measurement and Health IT strategies are embedded in each driver.
- All Cross cutting strategies are color coded to secondary drivers
- Reorganized the presentation of primary drivers to two key drivers, and then expressed the continuation of the work started in Award Year 1within the secondary drivers

The reorganization lays out Iowa's two-pronged approach; payment reform balanced by delivery system reform. The cross cutting drivers are key aspects woven into both payment and delivery system reform and are further illustrated in Figure 3 (below the Vision driver diagram).

Figure 2: Iowa SIM Vision Statement & Driver Diagram

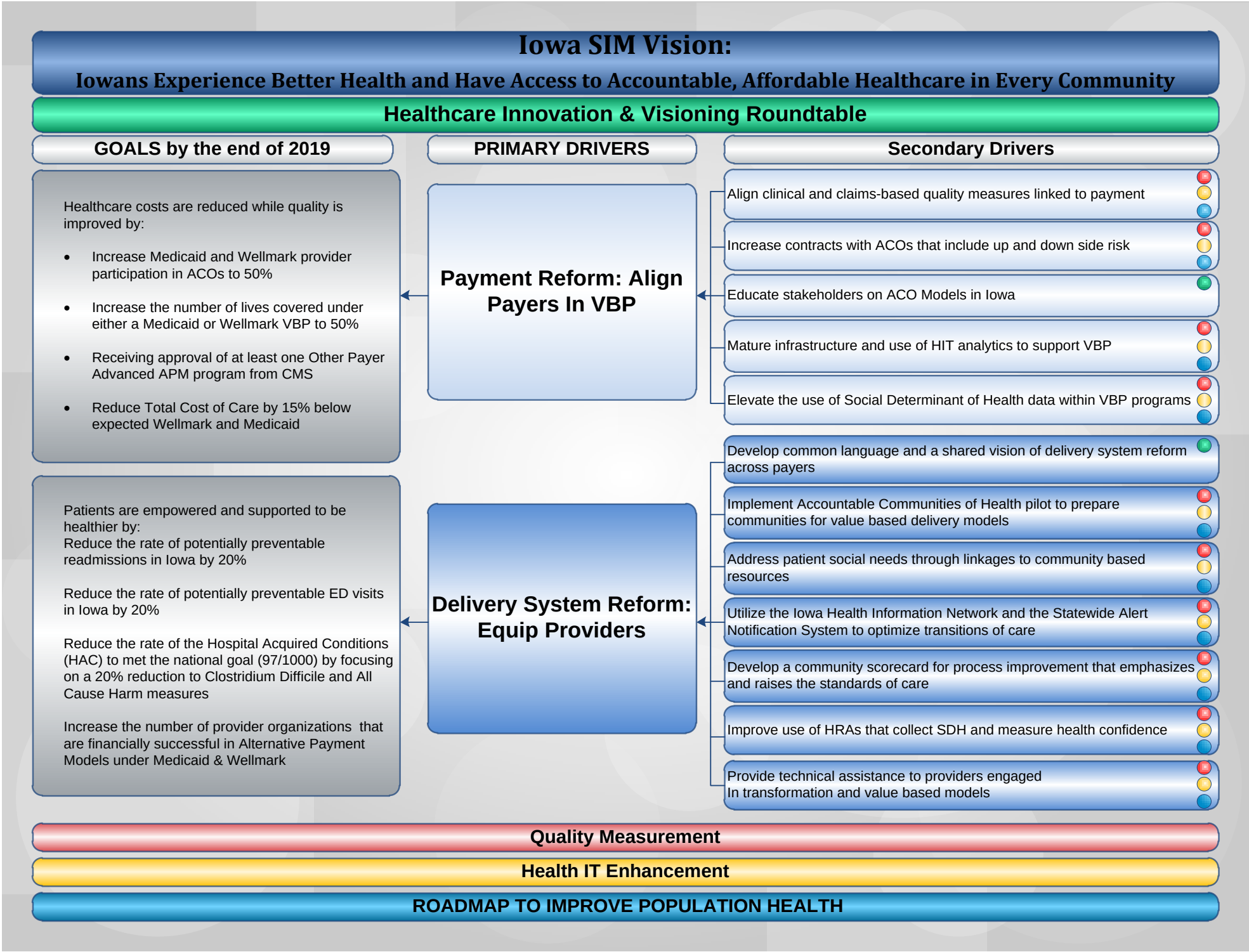
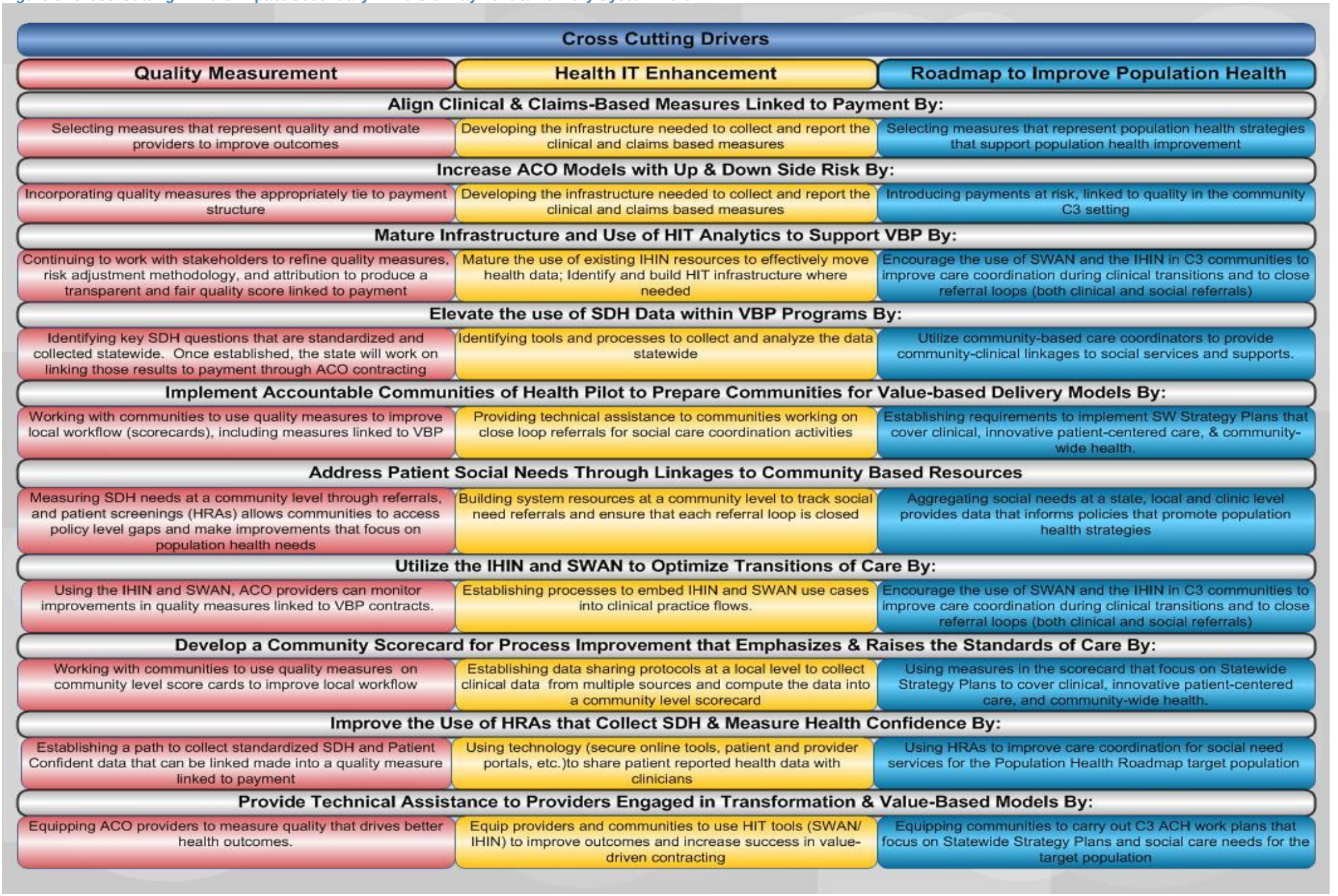


Figure 3: Cross-Cutting Drivers Impact Secondary Drivers of Payment & Delivery System Reform



4. Master Timeline

The state has adjusted the plans for Award Year 3 in several areas. More detail has been written to explain the AY3 activities in Section B and Section C of this document please refer there for more complete details and use this list as a high level summary of the changes:

- When the AY2 Operational Plan was submitted in November of 2015, the MACRA legislation around Other Payer Advanced Alternative Payment Models was not contemplated. There are new goals, milestones and action steps identified in AY3 due to MACRA.
- Incorporation of LTSS and Duals data into the state calculated VIS and TCOC calculations for ACOs has been delayed. The effort to collect, validate, and analyze the encounter data for the three new MCOs is more challenging than initially estimated while simultaneously implementing managed care. The state has now taken the approach to exclude LTSS/Duals from the VIS and TCOC calculations for APMs for 2017 and 2018, with the intent to integrate these data by 2019.
- AssesMyHealth was Medicaid's tool to conduct Health Risk Assessments in Iowa. It was used by providers in 2014 and 2015 to implement the Healthy Behavior program. Managed Care Organizations were encouraged to use AssessMyHealth, but not required. This has caused the state to evaluate the next steps necessary to advance the collection of standard Social Determinant data and patient reported health confidence as a tool to improve patient care. The AY3 milestones reflect the steps the state is pursing in this effort.

Award Year 2 and Award Year 3 Master Timeline

Task Name	% Complete	Start	Finish	SIM Activity	Milestone	Budget Narrative Mapping	Stage of work	Award Year (1 - 4)
Iowa SIM Initiative	**41%**	**Tue 7/1/14**	**Fri 8/30/19**		**Yes**			
Grant and IME Program Administration	**59%**	**Thu 1/1/15**	**Fri 8/30/19**		**No**			
Perform Project Management	**55%**	**Thu 10/1/15**	**Fri 8/30/19**	**Grant Administration**	**No**			
Operational Plan 2017	**78%**	**Fri 7/1/16**	**Mon 4/30/18**	**Grant Administration**	**No**	**Telligen SOW 1**		**2**
Milestone - Submit Operational AY3	90%	Tue 2/28/17	Tue 2/28/17	Grant Administration	Yes	Telligen SOW 1	Planning	2
Milestone - Receive Written Approval AY3 Operational Plan from CMS	0%	Fri 3/31/17	Fri 3/31/17	Grant Administration	Yes	Telligen SOW 1	Planning	2
Milestone - Establish 2017 Talking Points for SIM for Public Speaking events	0%	Wed 5/31/17	Wed 5/31/17	Grant Administration	Yes	Telligen SOW 1	Planning	3
Milestone - Submit 2016 Carry Over Request (if needed)	0%	Wed 5/31/17	Wed 5/31/17	Grant Administration	Yes	Telligen SOW 1	Planning	3
Operational Plan AY4	**0%**	**Sun 10/1/17**	**Fri 8/30/19**	**Grant Administration**	**No**	**Telligen SOW 1**		**3**
Milestone - Submit Operational Plan AY4	0%	Wed 2/28/18	Wed 2/28/18	Grant Administration	Yes	Telligen SOW 1	Planning	3
Milestone - Receive Written Approval of Operational Plan from CMS	0%	Fri 3/30/18	Fri 3/30/18	Grant Administration	Yes		Planning	3
Milestone - Establish 2018 Talking Points for SIM for Public Speaking events	0%	Fri 3/30/18	Fri 3/30/18	Grant Administration	Yes	Telligen SOW 1	Planning	3
Model Test Reporting	**40%**	**Thu 1/1/15**	**Tue 4/30/19**	**Grant Administration**	**No**			
Pre-Implementation (AY1) Reports to CMS	**100%**	**Fri 4/3/15**	**Fri 4/29/16**	**Grant Administration**	**No**	**Telligen SOW 1- 4**	**execution**	
Quarterly Progress Report 4	100%	Tue 3/1/16	Tue 3/1/16	Grant Administration	Yes	Telligen SOW 1 - 4	execution	2
Annual report 1 to CMS	**100%**	**Fri 4/29/16**	**Fri 4/29/16**	**Grant Administration**	**Yes**	**Telligen SOW 1 - 4**	**execution**	
Annual FFR to CMS	100%	Fri 4/29/16	Fri 4/29/16	Grant Administration	Yes	Telligen SOW 1- 4	execution	2

Task Name	% Complete	Start	Finish	SIM Activity	Milestone	Budget Narrative Mapping	Stage of work	Award Year (1 - 4)
Model Testing Award Year 2	**50%**	**Fri 4/29/16**	**Fri 4/28/17**	**Grant Administration**	**No**	**Telligen SOW 1- 4**	**execution**	
Progress Report to Legislators (SF 505 pg. 39, section 20) - See Annual Report	100%	Fri 4/29/16	Fri 4/29/16	Grant Administration	Yes	Telligen SOW 1- 4	execution	2
Milestone - Quarterly Progress Report 1	100%	Mon 5/30/16	Mon 5/30/16	Grant Administration	Yes	Telligen SOW 1 - 4	execution	2
Milestone -Quarterly Progress Report 2	100%	Tue 8/30/16	Tue 8/30/16	Grant Administration	Yes	Telligen SOW 1 - 4	execution	2
Milestone - Quarterly Progress Report 3	100%	Wed 11/30/16	Wed 11/30/16	Grant Administration	Yes	Telligen SOW 1 - 4	execution	2
Milestone - Request a non-Competing Continuation award (SF-424, SF-424A, Budget Narrative and updated Operational Plan)	100%	Tue 2/28/17	Tue 2/28/17	Grant Administration	Yes	Telligen SOW 1 - 4	execution	2
Milestone - Quarterly Progress Report 4	100%	Thu 3/9/17	Thu 3/9/17	Grant Administration	Yes	Telligen SOW 1 - 4	execution	2
Milestone - Annual report 2 to CMS	0%	Fri 4/28/17	Fri 4/28/17	Grant Administration	Yes	Telligen SOW 1 - 4	execution	3
Model Testing Award Year 3	**0%**	**Tue 5/30/17**	**Mon 4/30/18**	**Grant Administration**	**No**	**Telligen SOW 1 - 4**	**execution**	
Annual AY3 Report to CMS	0%	Mon 4/30/18	Mon 4/30/18	Grant Administration	Yes	Telligen SOW 1 - 4	execution	4
Plan to Improve Population Health	**10%**	**Sun 2/1/15**	**Thu 1/31/19**	**Pop Health**	**No**			
Project Management of the Population Health Roadmap	**20%**	**Mon 4/30/18**	**Wed 5/30/18**	**Pop Health**	**Yes**	**IDPH SOW 1**	**execution**	
Milestone - Educate payers on benefits of DSME, NDPP, and CDSMP and payment barrier	0%	Mon 4/30/18	Mon 4/30/18	Pop Health	Yes	IDPH SOW 1	execution	3
Milestone - Monitor and report progress on Population Health Roadmap measures	0%	Mon 4/30/18	Mon 4/30/18	Pop Health	Yes	IDPH SOW 1	execution	3
Award Year 3 IDPH C3 Oversight and TA	**0%**	**Wed 2/1/17**	**Wed 1/31/18**	**C3s**	**No**			**3**

Task Name	% Complete	Start	Finish	SIM Activity	Milestone	Budget Narrative Mapping	Stage of work	Award Year (1 - 4)
Milestone- Conduct gap analysis to each C3 Coalition to identify resource needs	0%	Thu 8/31/17	Thu 8/31/17	C3s	Yes	IDPH SOW 1	execution	3
Milestone - All C3 Coordinators complete Options Counselor training	0%	Thu 11/30/17	Thu 11/30/17	C3s	Yes	IDPH SOW 2	execution	3
Milestone - Link C3s and IDPH DSME and NDPP staff where gaps are found	0%	Mon 4/30/18	Mon 4/30/18	C3s	Yes	IDPH SOW1	execution	3
Milestone - Conduct gap analysis for DSME and NDPP in C3 regions	0%	Mon 4/30/18	Mon 4/30/18	C3s	Yes	IDPH SOW1	execution	3
Milestone - Develop referral process between C3s and the Healthiest State Initiative	0%	Wed 1/31/18	Wed 1/31/18	C3s	Yes	IDPH SOW1	execution	3
Milestone- Conduct initial assessment of current workforce to inform training	0%	Thu 11/30/17	Thu 11/30/17	C3s	Yes	IDPH SOW1	execution	3
Align Pop Health Roadmap with CHNA/HIP Process	**0%**	**Sun 12/31/17**	**Sun 12/31/17**	**Pop Health**	**Yes**			
Milestone - Elicit feedback regarding health improvement strategies from at least 50 stakeholder groups including other statewide health improvement initiatives.	100%	Sun 7/31/16	Sun 7/31/16	Pop Health	Yes	IDPH SOW 1	execution	2
Milestone - Complete analysis of and report on 100% of county CHNAs.	100%	Mon 8/1/16	Mon 8/1/16	Pop Health	Yes	IDPH SOW 1	Execution	2
Milestone - Analyze 100% of county HIPs to identify the number of counties with hospitals integrated in their HIP.	0%	Sun 4/30/17	Sun 4/30/17	Pop Health	Yes	IDPH SOW 1	Execution	2
Milestone - Analyze 100% of county CHNA&HIPs to understand how social determinants of health are being addressed statewide.	0%	Sun 4/30/17	Sun 4/30/17	Pop Health	Yes	IDPH SOW 1	Execution	2
Milestone - Assess CHNA HIP for alignment with required SWS tactics within C3 action plans	0%	Fri 12/29/17	Fri 12/29/17	Pop Health	Yes	IDPH SOW 1	Execution	3

Task Name	% Complete	Start	Finish	SIM Activity	Milestone	Budget Narrative Mapping	Stage of work	Award Year (1 - 4)
Milestone - Identify the number of Iowans covered by a HIP that includes SIM focus areas of diabetes, tobacco, and obesity strategies.	90%	Sun 4/30/17	Sun 4/30/17	C3s	Yes	IDPH SOW 2	execution	2
Milestone - Complete 2017 Healthy Iowans state health improvement plan.	0%	Tue 2/28/17	Tue 2/28/17	Pop Health	Yes	IDPH SOW 1	Execution	2
Community and Clinical Care Initiative (C3) Pilots	**13%**	**Sun 2/1/15**	**Thu 1/31/19**	**Pop Health**	**No**			
Project Management of the C3 RFP	**13%**	**Tue 2/14/17**	**Fri 6/29/18**	**Pop Health**	**No**		**Execution**	
Milestone - Prepare funding opportunity announcement	100%	Tue 2/14/17	Tue 2/14/17	C3s	Yes	IDPH SOW 2	Execution	2
Milestone - Release the RFP for AY3	100%	Tue 2/14/17	Tue 2/14/17	C3s	Yes	IDPH SOW 2	Execution	2
Milestone - Award/Execute contracts for AY3 C3s	0%	Sun 4/30/17	Sun 4/30/17	C3s	Yes	IDPH SOW 2	Execution	2
Milestone - C3/IDPH Collaboration Meeting Spring/Summer	0%	Thu 8/31/17	Thu 8/31/17	C3s	Yes	IDPH SOW 2	execution	3
Milestone - C3/IDPH Collaboration Meeting Fall/Winter	0%	Wed 2/28/18	Wed 2/28/18	C3s	Yes	IDPH SOW 2	execution	3
Milestone - Compile success stories and lessons learned from C3 quarter 1 and quarter 2 reports	0%	Fri 12/29/17	Fri 12/29/17	C3s	Yes	IDPH SOW 2	execution	3
Milestone - Release C3 funding opportunity for AY4	0%	Wed 2/28/18	Wed 2/28/18	C3s	Yes	IDPH SOW 2	execution	3
Milestone - Execute AY4 C3 contracts	0%	Mon 4/30/18	Mon 4/30/18	C3s	Yes	IDPH SOW 2	execution	3
Milestone - Compile success stories and lessons learned from C3 quarter 3 and quarter 4 reports	0%	Fri 6/29/18	Fri 6/29/18	C3s	Yes	IDPH SOW 2	execution	4
Expand the Implementation and Utilization of Statewide Strategy Plans	**0%**	**Sun 7/31/16**	**Mon 4/30/18**		**No**			
Milestone - Elicit feedback regarding health improvement strategies from at least 50 stakeholder groups including	100%	Sun 7/31/16	Sun 7/31/16	Pop Health	Yes	IDPH SOW 1	Execution	2

Task Name	% Complete	Start	Finish	SIM Activity	Milestone	Budget Narrative Mapping	Stage of work	Award Year (1 - 4)
other statewide health improvement initiatives.								
Milestone - Provide Iowa SIM statewide strategy plans to a minimum of five counties identifying a SIM statewide strategy in the Health Improvement Plan.	0%	Sun 4/30/17	Sun 4/30/17	Pop Health	Yes	IDPH SOW 1	Execution	2
Milestone - Conduct a minimum of two SDH workgroup meetings	95%	Sun 4/30/17	Sun 4/30/17	Pop Health	Yes	IDPH SOW 1	Execution	2
Milestone -Complete yearly updates to diabetes, care coordination, SDH, PFE, obesity, and tobacco statewide Strategy Plans	0%	Mon 4/30/18	Mon 4/30/18	Pop Health	Yes	IDPH SOW 1	Execution	3
Milestone - Complete activities from statewide strategy plan tactics in 3 of the 7 required C3 objectives.	0%	Wed 2/28/18	Wed 2/28/18	C3s	Yes	IDPH SOW 2	Execution	3
Milestone - Complete activities from statewide strategy plan tactics in 7 of the 7 required C3 objectives.	0%	Mon 4/30/18	Mon 4/30/18	C3s	Yes	IDPH SOW 2	Execution	3
Milestone - Provide Iowa SIM statewide strategy plans to a minimum of five additional counties (10 total) identifying diabetes in the Health Improvement Plan.	0%	Wed 2/28/18	Wed 2/28/18	Pop Health	Yes	IDPH SOW 2	Execution	3
Milestone - Provide Iowa SIM statewide strategy plans to a minimum of five additional counties (15 total for AY2 and 3) identifying diabetes in the Health Improvement Plan.	0%	Mon 4/30/18	Mon 4/30/18	Pop Health	Yes	IDPH SOW 1	Execution	3
Delivery System Reform	**15%**	**Tue 7/1/14**	**Wed 5/1/19**		**No**			
Healthcare System Technical Assistance	**20%**	**Tue 3/8/16**	**Thu 5/31/18**	**SIM Technical Assistance**	**No**			
SIM Learning Events AY2	**75%**	**Tue 3/8/16**	**Thu 3/9/17**	SIM Technical Assistance	**No**			
Milestone - Convene the 2nd SIM Learning Collaborative	100%	Tue 3/8/16	Tue 3/8/16	SIM Technical Assistance	Yes	IDPH SOW 5	execution	2

Task Name	% Complete	Start	Finish	SIM Activity	Milestone	Budget Narrative Mapping	Stage of work	Award Year (1 - 4)
Milestone - Convene the 3rd SIM Learning Collaborative	100%	Tue 7/12/16	Tue 7/12/16	SIM Technical Assistance	Yes	IDPH SOW 5	execution	2
Milestone - Convene the 4th SIM Learning Collaborative	100%	Wed 11/9/16	Wed 11/9/16	SIM Technical Assistance	Yes	IDPH SOW 5	execution	2
Milestone - Convene the 5th SIM Learning Collaborative	100%	Thu 3/9/17	Thu 3/9/17	SIM Technical Assistance	Yes	IDPH SOW 5	execution	2
SIM Learning Events - AY3	**0%**	**Wed 7/12/17**	**Wed 4/11/18**	SIM Technical Assistance	**No**			
Milestone - Convene AY3 Summer Learning Event	0%	Wed 7/12/17	Wed 7/12/17	SIM Technical Assistance	Yes	IHC SOW 6	execution	3
Milestone - Convene AY3 Fall Learning Event	0%	Thu 11/9/17	Thu 11/9/17	SIM Technical Assistance	Yes	IHC SOW 6	execution	3
Milestone - Convene AY3 Spring 2018 Learning Event	0%	Wed 4/11/18	Wed 4/11/18	SIM Technical Assistance	Yes	IHC SOW 6	execution	3
Provide TA to Providers Engaged in VBP	**0%**	**Mon 4/30/18**	**Mon 4/30/18**	SIM Technical Assistance	**No**			
Milestone-Develop and implement a statewide strategy for Health System alignment, prioritizing statewide standards of care	0%	Mon 4/30/18	Mon 4/30/18	SIM Technical Assistance	Yes	IHC SOW 1	execution	3
Milestone-Host facilitated networking, sharing and brainstorming to engage large health systems in SIM work and leverage their assistance in statewide improvement efforts including the Community Scorecard	0%	Mon 4/30/18	Mon 4/30/18	SIM Technical Assistance	Yes	IHC SOW 1 and 4	execution	3
Milestone-Convene workgroups to develop a physician/clinician engagement strategy and tools to support health systems in advancing clinicians and ACOs in the QPP	0%	Thu 5/31/18	Thu 5/31/18	SIM Technical Assistance	Yes	IHC SOW 1 and 4	execution	3
Milestone-Provide access to virtual education sessions within the IA HIIN and IA TCPI Programs for clinic providers not enrolled in the programs	0%	Mon 4/30/18	Mon 4/30/18	SIM Technical Assistance	Yes	IHC SOW 1 and 4	execution	3

Task Name	% Complete	Start	Finish	SIM Activity	Milestone	Budget Narrative Mapping	Stage of work	Award Year (1 - 4)
Conduct workgroup sessions that include clinic, community and hospital stakeholders to align strategies to reduce HAC (c.Diff, All Case Harm, ADE, etc...)	0%	Mon 4/30/18	Mon 4/30/18	SIM Technical Assistance	Yes	IHC SOW 1 and 4	execution	3
Equip Delivery System and Accountable Communities of Health Pilots (C3s)	**39%**	**Tue 7/1/14**	**Mon 4/30/18**	**C3s**	**No**			
Award Year 2 Community TA for C3s	**95%**	**Tue 8/18/15**	**Mon 4/30/18**		**No**			
Milestone - Develop a minimum of one informational document highlighting the C3 communities and the planned initiatives, planned social determinants of health interventions, and applicable health improvement plan elements.	100%	Fri 4/1/16	Fri 4/29/16	C3s	Yes	IDPH SOW 1		2
Milestone - Disseminate C3 informational document to a minimum of six partners (i.e., CDC 1305 Partnership Grant for Diabetes, Nutrition and Physical Activity; Division of Tobacco Use Prevention and Control; IDPH, IHA)	100%	Sun 7/31/16	Sun 7/31/16	C3s	Yes	IDPH SOW 1		2
Milestone - Hire C3 project directors	100%	Fri 9/30/16	Fri 9/30/16	C3s	Yes	IDPH SOW 2, 4		2
Milestone -Establish steering committees in C3 developmental communities	100%	Wed 11/30/16	Wed 11/30/16	C3s	Yes	IDPH SOW 2, 4		2
Milestone -Develop referral flow charts in C3 implementation communities	0%	Tue 2/28/17	Tue 2/28/17	C3s	Yes	IDPH SOW 2, 4		2
Milestone - Implement a minimum of one intervention for diabetes, obesity and tobacco statewide strategy plans each C3 has selected	15%	Fri 4/28/17	Fri 4/28/17	C3s	Yes	IDPH SOW 2, 4		2
Milestone - Incorporate a minimum of one supplemental strategy	5%	Fri 4/28/17	Fri 4/28/17	C3s	Yes	IDPH SOW 2, 4		2
Milestone - Develop a minimum of	95%	Fri 12/30/16	Tue 2/28/17	C3s	Yes	IDPH SOW		2

Task Name	% Complete	Start	Finish	SIM Activity	Milestone	Budget Narrative Mapping	Stage of work	Award Year (1 - 4)
one informational document on the successes and lessons learned of Year 1 CCT pilot and Year 2 C3 communities first and second quarter reporting.						1		
Milestone - Develop draft Iowa Community Care Coalition Model	100%	Wed 11/30/16	Wed 11/30/16	C3s	Yes	IDPH SOW 1		2
Milestone - Prepare funding opportunity announcement	100%	Wed 11/30/16	Wed 11/30/16	C3s	Yes	IDPH SOW 1		2
Milestone - Complete SIM year two C3 contracts	0%	Fri 4/28/17	Fri 4/28/17	C3s	Yes	IDPH SOW 1		2
Milestone - Assign 2 Quality Improvement Advisors to C3s	100%	Mon 7/31/16	Mon 7/31/16	Rapid Cycle Improve	Yes	IHC SOW 2	execution	2
Milestone- Maintain C3 communication platform (SIMplify)	0%	Mon 4/30/18	Mon 4/30/18	SIM Technical Assistance	Yes	IHC SOW 2	execution	3
Milestone - Implement a collaborative strategy for C3 communication, interactions, and assistance(SIMplify)	100%	Fri 7/29/16	Fri 7/29/16	SIM Technical Assistance	Yes	IDPH SOW 5	execution	2
Milestone - C3s finalize charters	100%	Thu 6/30/16	Thu 6/30/16	C3s	Yes	IDPH SOW 5	execution	2
Milestone - Complete baseline assessment for all C3s	100%	Fri 4/29/16	Fri 4/29/16	SIM Technical Assistance	Yes	IDPH SOW 5	execution	2
Milestone - Initial C3 project data and quality measurement plan in place	100%	Thu 6/30/16	Thu 6/30/16	SIM Technical Assistance	Yes	IDPH SOW 5	execution	2
Milestone - IHC SIM Project reporting database operational	100%	Mon 10/31/16	Mon 10/31/16	SIM Technical Assistance	Yes	IDPH SOW 5	execution	2
Milestone - IHC Communications Platform Active	100%	Tue 5/10/16	Tue 5/10/16	SIM Technical Assistance	Yes	IDPH SOW 5	execution	2
Milestone -Identify and promote 3 C3 success stories-RCPI	100%	Mon 10/31/16	Mon 10/31/16	SIM Technical Assistance	Yes	IDPH SOW 5	execution	2
Milestone - Support C3 projects with CHNA/HIP priorities	100%	Fri 7/29/16	Fri 7/29/16	SIM Technical Assistance	Yes	IDPH SOW 5	execution	2
Milestone - C3 project data baselines established	100%	Fri 10/14/16	Fri 10/14/16	SIM Technical Assistance	Yes	IDPH SOW 5	execution	2

Task Name	% Complete	Start	Finish	SIM Activity	Milestone	Budget Narrative Mapping	Stage of work	Award Year (1 - 4)
Milestone - Develop an SDH toolkit and distribute to all six C3 communities.	80%	Fri 4/28/17	Fri 4/28/17	SIM Technical Assistance	Yes	IDPH SOW 5	execution	2
Milestone - Convene one SDH SIMplify Forum	100%	Thu 1/19/17	Thu 1/19/17	SIM Technical Assistance	Yes	IDPH SOW 5	execution	2
Milestone - Assure completion and submission of six 4th quarter QI work plans to IHC SIM portal	75%	Fri 4/28/17	Fri 4/28/17	SIM Technical Assistance	Yes	IDPH SOW 5		2
Milestone - Complete medication management/safety interviews with six C3s	100%	Tue 2/28/17	Tue 2/28/17	SIM Technical Assistance	Yes	IDPH SOW 5	execution	2
Milestone - Annual report on progress for SIM TA projects	0%	Tue 5/30/17	Tue 5/30/17	SIM Technical Assistance	Yes	IDPH SOW 5	execution	3
Provide TA to C3 Regions and Partners for Community Referral Services	**0%**	**Mon 4/30/18**	**Mon 4/30/18**	SIM Technical Assistance	**No**			
Milestone - Analyze C3 self-reported referral data in each C3 Region	0%	Fri 7/28/17	Fri 7/28/17	SIM Technical Assistance	Yes	IHC SOW 2	execution	3
Milestone - Verify Referral Process needs for each C3 (leadership)	0%	Fri 6/30/17	Fri 6/30/17	SIM Technical Assistance	Yes	IHC SOW 2	execution	3
Milestone - Identify tools/resources for TA Needs	0%	Fri 6/30/17	Fri 6/30/17	SIM Technical Assistance	Yes	IHC SOW 2	execution	3
Milestone - Provide Referral Process TA to each C3 Region and Partners	0%	Fri 6/30/17	Mon 4/30/18	SIM Technical Assistance	Yes	IHC SOW 2	execution	3
Milestone-Develop process map or flow chart to demonstrate roles in the healthcare system	0%	Mon 4/30/18	Mon 4/30/18	SIM Technical Assistance	Yes	IHC SOW 2	execution	3
Milestone-Provide training to hospitals and C3s to establish process for adoption of best practices and process improvement	0%	Mon 4/30/18	Mon 4/30/18	SIM Technical Assistance	Yes	IHC SOW 2	execution	3
Provide TA for Social Needs Screenings for C3 Regions and Partners	**0%**	**Fri 6/30/17**	**Thu 8/31/17**	SIM Technical Assistance	**Yes**		**execution**	

Task Name	% Complete	Start	Finish	SIM Activity	Milestone	Budget Narrative Mapping	Stage of work	Award Year (1 - 4)
Milestone - Complete Environmental Scan for social need collection/screenings/provider knowledge	0%	Wed 8/23/17	Wed 8/23/17	SIM Technical Assistance	Yes	IHC SOW 5	execution	3
Milestone - Identify tools/resources for SDH TA Needs	0%	Mon 4/30/18	Mon 4/30/18	SIM Technical Assistance	Yes	IHC SOW 5	execution	3
Milestone - Provide local and state level SDH Education and training	0%	Mon 4/30/18	Mon 4/30/18	SIM Technical Assistance	Yes	IHC SOW 5	execution	3
Provide TA to C3 Regions and Partners for Mapping Tool Capabilities	**0%**	**Tue 5/30/17**	**Mon 4/30/18**	SIM Technical Assistance	**Yes**		**execution**	
Milestone - Provide Mapping TA including ChimeMap to each C3 Region and Partners	0%	Mon 4/30/18	Mon 4/30/18	SIM Technical Assistance	Yes	IHC SOW 5	execution	3
Milestone - Assess Needs and knowledge to use mapping tool	0%	Tue 5/30/17	Tue 5/30/17	SIM Technical Assistance	Yes	IHC SOW2	execution	3
Provide TA to C3 Regions and Partners for Process Improvement	**0%**	**Mon 4/30/18**	**Mon 4/30/18**	SIM Technical Assistance	**No**		**execution**	
Milestone - All C3s reporting data to SIM to populate Community Scorecards	0%	Mon 4/30/18	Mon 4/30/18	SIM Technical Assistance	Yes	IHC SOW 3	execution	3
Milestone - All C3s submit SIM Community Quality Improvement Plan - Focus One QI Process Measure	0%	Mon 5/1/17	Mon 5/1/17	C3s	Yes	IDPH SOW 2	execution	3
Milestone - C3 Survey Needs for Rapid Cycle Performance Improvement	0%	Mon 5/1/17	Mon 5/1/17	SIM Technical Assistance	Yes	IHC SOW 2	execution	3
Milestone - Connect with each Health System working in a C3 to engage in Process Improvement	0%	Mon 5/1/17	Mon 5/1/17	SIM Technical Assistance	Yes	IHC SOW 2	execution	3
Milestone- Assist C3s in developing DSME where needed	0%	Sun 12/31/17	Sun 12/31/17	SIM Technical Assistance	Yes	IDPH SOW 1	execution	3
Milestone-Develop referral systems and feedback loops for C3s related to DSME programs	0%	Sun 12/31/17	Sun 12/31/17	C3s	Yes	IDPH SOW 2	execution	3
Milestone-Distribute updated Statewide Strategy Plans to local communities and collaborative partners	0%	Mon 5/1/17	Mon 5/1/17	SIM Technical Assistance	Yes	IDPH SOW 2	execution	3

Task Name	% Complete	Start	Finish	SIM Activity	Milestone	Budget Narrative Mapping	Stage of work	Award Year (1 - 4)
Milestone- Create unique tracking and value calculations for diabetic patients with A1c>9 with vascular disease, tobacco use, obesity	0%	Fri 12/1/17	Fri 12/1/17	SIM Technical Assistance	Yes	IHC SOW 3	execution	3
Maintain SIM Data Portal Capacity	**0%**	**Tue 7/1/14**	**Mon 1/15/18**	SIM Technical Assistance	**No**		**execution**	
Milestone-Incorporate SIM core metrics and Assess My Health data in State Health Improvement Plan where possible	0%	Thu 11/30/17	Thu 11/30/17	SIM Technical Assistance	Yes	IDPH SOW…	execution	3
Milestone – Create All Cause Harm baseline and annual tracking process for this measure to align with national goal to reduce HAC	0%	Mon 7/31/17	Mon 7/31/17	SIM Technical Assistance	Yes	IHC SOW 6	Execution	3
Milestone-Provide C3 virtual training for data analytics and data communication skills	0%	Mon 4/30/18	Mon 4/30/18	SIM Technical Assistance	Yes	IHC SOW 6	execution	3
Milestone-Develop and provide C3 Community Score Cards based on SIM portal data analytics	**0%**	**Mon 4/30/18**	**Mon 4/30/18**	**SIM Technical Assistance**	**Yes**		**execution**	**3**
Provide TA for C3 Regions and Partners to Utilize SWAN for Care Transition	**0%**	**Mon 4/30/18**	**Mon 4/30/18**	SIM Technical Assistance	**No**		**execution**	
Milestone- Develop referral systems and feedback loops for SDOH using HIT	0%	Tue 10/31/17	Tue 10/31/17	SIM Technical Assistance	Yes	IHC SOW 1	execution	3
Milestone-convene groups to determine measures and develop non-C3 Community Scorecards	0%	Mon 4/30/18	Mon 4/30/18	SIM Technical Assistance	Yes	IHC SOW 4	execution	3
Milestone - develop provider engagement resources	0%	Mon 4/30/18	Mon 4/30/18	SIM Technical Assistance	Yes	IHC SOW 1	execution	3
Milestone - Subcontract with IA Hospital Assoc., IA Pharmacy Assoc., IA Primary Care Assoc., and IA Medical Society to support health system	0%	Mon 4/30/18	Mon 4/30/18	SIM Technical Assistance	Yes	IHC SOW 5	execution	3

Task Name	% Complete	Start	Finish	SIM Activity	Milestone	Budget Narrative Mapping	Stage of work	Award Year (1 - 4)
transitions activities within their membership. (See page 68 of the Operational Plan)								
Milestone - convene process for Health Systems SWS	0%	Mon 4/30/18	Mon 4/30/18	SIM Technical Assistance	Yes	IHC SOW 1	execution	3
Milestone - convene and facilitate meetings to align strategies on common metrics	0%	Mon 4/30/18	Mon 4/30/18	SIM Technical Assistance	Yes	IHC SOW 1-6	execution	3
Milestone -Support stakeholder groups to determine path toward transformative OA - AAPM.	0%	Mon 4/30/18	Mon 4/30/18	SIM Technical Assistance	Yes	IHC SOW 1	execution	3
Milestone - Expand secure Simplify Portal to include Health Systems communications	0%	Mon 4/30/18	Mon 4/30/18	SIM Technical Assistance	Yes	IHC SOW 5	execution	3
Milestone - Assign two data analysts to support health systems transformation TA.	0%	Tue 5/30/17	Tue 5/30/17	SIM Technical Assistance	Yes	IHC SOW 1	execution	3
Milestone - Assign program manager and project officer to support health systems transformation	0%	Tue 5/30/17	Tue 5/30/17	SIM Technical Assistance	Yes	IHC SOW 1	execution	3
Milestone - Develop process map or flow chart to demonstrate roles in the healthcare system	0%	Mon 4/30/18	Mon 4/30/18	SIM Technical Assistance	Yes	IHC SOW 1	execution	3
Milestone - Expand SIM Portal to collect and analyze non-C3 community scorecard data	0%	Mon 4/30/18	Mon 4/30/18	SIM Technical Assistance	Yes	IHC SOW 6	execution	3
SWAN Development to Improve Transition of Care	**13%**	**Tue 7/1/14**	**Wed 5/1/19**	**SWAN**	**No**			
Promote EHR adoption among providers (EHR Incentive Program)	0%	Thu 1/1/15	Mon 12/31/18	SWAN	Yes	IHIN Non Profit SOW 1		3
IDPH Project Management for Alerting System (necessary staffing) to oversee contract work, stakeholder support and SIM grant requirements	0%	Mon 2/2/15	Mon 12/31/18	SWAN	Yes	IHIN Non Profit SOW 1		3

Task Name	% Complete	Start	Finish	SIM Activity	Milestone	Budget Narrative Mapping	Stage of work	Award Year (1 - 4)
IME Review System Development and Implementation timeline	**100%**	**Fri 1/30/15**	**Wed 9/30/15**	**SWAN**	**No**			
Milestone -Deploy an alerting system for ADT information for ACOs and other primary care providers, including reporting	100%	Wed 9/30/15	Wed 9/30/15	SWAN	Yes	IDPH SOW 6		2
Connect ALL Iowa Hospitals to SWAN to send ADT Files	**76%**	**Tue 7/1/14**	**Wed 5/1/19**	**SWAN**	**No**			
Milestone - Set up 5 connections to SWAN by April 30, 2016	100%	Fri 4/1/16	Fri 4/1/16	SWAN	Yes	IDPH SOW 6		2
Milestone - Connect 20 Iowa Hospitals to SWAN	100%	Thu 5/5/16	Thu 5/5/16	SWAN	Yes	IDPH SOW 6		2
Milestone - Connect 30 Iowa Hospitals to SWAN	100%	Wed 2/1/17	Fri 5/19/17	SWAN	Yes	IDPH SOW 6		2
Milestone - At least one user from every ACO signed up and ready to receive Alerts	100%	Wed 6/1/16	Wed 6/1/16	SWAN	Yes	IDPH SOW 6		2
Milestone - Establish 10% of the ACOs Receiving Alerts	100%	Sun 1/31/16	Sun 1/31/16	SWAN	Yes	IDPH SOW 6		2
Milestone - Establish 40% of the ACOs Receiving Alerts	100%	Thu 3/31/16	Thu 3/31/16	SWAN	Yes	IDPH SOW 6		2
Milestone - Establish remaining 50% of the ACOs Receiving Alerts	100%	Fri 7/1/16	Fri 7/1/16	SWAN	Yes	IDPH SOW 6		2
Milestone - ADT Data received from 15 additional hospitals	0%	Mon 7/31/17	Mon 7/31/17	SWAN	Yes	IHIN Non Profit SOW 1 and 2		3
Milestone - ADT Data received from 15 additional hospitals	0%	Thu 11/30/17	Thu 11/30/17	SWAN	Yes	IHIN Non Profit SOW 1 and 2		3
Milestone - ADT Data received from 15 additional hospitals	0%	Sat 3/31/18	Sat 3/31/18	SWAN	Yes	IHIN Non Profit SOW 1 and 2		3
Alerts Submitted by ACO Affiliated Hospitals are “Real Time"	**0%**	**Tue 8/1/17**	**Thu 2/1/18**	**SWAN**	**No**			**3**
Milestone - Mercy ACO	0%	Tue 8/1/17	Tue 8/1/17	SWAN	Yes	IHIN Non		3

Task Name	% Complete	Start	Finish	SIM Activity	Milestone	Budget Narrative Mapping	Stage of work	Award Year (1 - 4)
submitting ADT data more than once per day						Profit SOW 1 and 2		
Milestone - Mercy ACO submitting Real Time ADT data	0%	Thu 2/1/18	Thu 2/1/18	SWAN	Yes	IHIN Non Profit SOW 1 and 2		3
Increase the number of organizations receiving Alerts on Medicaid Members	**0%**	**Thu 6/1/17**	**Thu 2/1/18**	**SWAN**	**No**			
Milestone - Receive a Medicaid Eligibility file from 3 Medicaid ACOs	0%	Thu 6/1/17	Thu 6/1/17	SWAN	Yes	IHIN Non Profit SOW 1 and 2		3
Milestone - Receive a Medicaid Eligibility file from ALL 5 Medicaid ACOs	0%	Fri 9/1/17	Fri 9/1/17	SWAN	Yes	IHIN Non Profit SOW 1 and 2		3
Milestone - Receive Medicaid Eligibility file from 1 Non-ACO Organization	0%	Thu 2/1/18	Thu 2/1/18	SWAN	Yes	IHIN Non Profit SOW 1 and 2		3
Expand SWAN Alerts to include the Medicare Population	**0%**	**Thu 6/1/17**	**Thu 2/1/18**	**SWAN**	**No**			
Milestone - Receive a MEDICARE Eligibility file from at least 1 ACO by	0%	Thu 6/1/17	Thu 6/1/17	SWAN	Yes	IHIN Non Profit SOW 1 and 2		3
Milestone - Receive a MEDICARE eligibility from at least 2 other ACOs	0%	Thu 2/1/18	Thu 2/1/18	SWAN	Yes	IHIN Non Profit SOW 1 and 2		3
Expand SWAN Alerts to Other Provider Types and Organizations	**0%**	**Mon 12/4/17**	**Thu 2/1/18**	**SWAN**	**No**			
Milestone - Pricing Model developed for other provider type or entities use of SWAN	0%	Mon 12/4/17	Mon 12/4/17	SWAN	Yes	IHIN Non Profit SOW 1		3
Milestone - At Least 1 Other Provider Type or Entity Submits Eligibility File	0%	Thu 2/1/18	Thu 2/1/18	SWAN	Yes	IHIN Non Profit SOW 1 and 2		3
SWAN TA (IHIN Non Profit)	**22%**	**Tue 7/1/14**	**Mon 12/31/18**	**SWAN**	**No**			
Milestone - Develop fact Sheet on	0%	Fri 6/2/17	Fri 6/2/17	SWAN	Yes	IHIN Non		3

Task Name	% Complete	Start	Finish	SIM Activity	Milestone	Budget Narrative Mapping	Stage of work	Award Year (1 - 4)
the value of sending ADT Data						Profit SOW 1		
Milestone -Conduct at least 5 User Group Meetings	0%	Mon 5/1/17	Tue 5/1/18	SWAN	Yes	IHIN Non Profit SOW 1		3
Milestone - Conduct an analysis of current ADT / SWAN data including Barriers, Risks & Enhancements	0%	Mon 7/3/17	Mon 7/3/17	SWAN	Yes	IHIN Non Profit SOW 1 and 2		3
Milestone - Document and distribute Best Practice for ADT/Alerting	0%	Fri 9/1/17	Fri 9/1/17	SWAN	Yes	IHIN Non Profit SOW 1 and 2		3
Milestone-Release Results of Best Practices with Key Partners	0%	Fri 9/1/17	Fri 9/1/17	SWAN	Yes	IHIN Non Profit SOW 1		3
SWAN Communication Plan	**41%**	**Tue 9/16/14**	**Mon 12/31/18**	**SWAN**	**No**			**3**
Milestone - Communication plan approved	100%	Fri 4/29/16	Tue 5/17/16	SWAN	Yes	IDPH SOW 6		2
Milestone - Annual review and update of communication Plan	100%	Thu 3/31/16	Thu 3/31/16	SWAN	Yes	IDPH SOW 6		2
Milestone - Annual review and update of communication Plan	0%	Fri 3/31/17	Fri 3/31/17	SWAN	Yes	IDPH SOW 6		2
Milestone - Annual review and update of communication Plan	0%	Thu 3/1/18	Thu 3/1/18	SWAN	Yes	IHIN Non Profit SOW 1		3
Work w/ stakeholders & other payers to increase covered lives in SWAN Alerting	**40%**	**Wed 6/15/16**	**Thu 11/1/18**	**SWAN**	**No**			**2**
Milestone- Give Presentation on SWAN to Care Coordinators	100%	Wed 6/15/16	Wed 6/15/16	SWAN	Yes	IDPH SOW 6		2
Milestone- Conduct Informational Session for C3 Directors	0%	Mon 10/2/17	Mon 10/2/17	SWAN	Yes	IHIN Non Profit SOW 1		3
Milestone - Submit Year 2 SWAN Perceived Value report to IME	100%	Wed 7/13/16	Wed 7/13/16	SWAN	Yes	IDPH SOW 6		2
Milestone- Conduct at least 5	100%	Sun 1/1/17	Sun 1/1/17	SWAN	Yes	IDPH SOW		2

Task Name	% Complete	Start	Finish	SIM Activity	Milestone	Budget Narrative Mapping	Stage of work	Award Year (1 - 4)
Face to Face Meetings, Conferences, for technical assistance regarding SWAN in 2016						6		
Enable other Payers to use SWAN	**0%**	**Tue 7/1/14**	**Wed 11/1/17**	**SWAN**	**No**			**1**
Milestone- Receive an eligibility file from 2 Medicaid MCOs	0%	Thu 8/31/17	Thu 8/31/17	SWAN	Yes	IHIN Non Profit SOW 1 and 2		3
Milestone - Receive an eligibility file from ALL Medicaid MCOs	0%	Sat 9/30/17	Sat 9/30/17	SWAN	Yes	IHIN Non Profit SOW 1 and 2		3
Standardize HRA Utilization for Collection and Use for SDH Measures	**0%**	**Fri 6/30/17**	**Tue 5/1/18**		**No**			
Milestone-Deploy Assess My Health as NCQA Certified Health Risk Screening Tool	0%	Fri 6/30/17	Fri 6/30/17	SDH/HRA	Yes	Telligen SOW 2	execution	3
Identify Social Determinants screening questions and add them to AMH and recommend for other tools	5%	Sat 9/30/17	Sat 9/30/17	SDH/HRA	Yes	Telligen SOW 2	execution	3
Milestone-Deploy AMH for use in the general population via Wellmark and HSI leadership	0%	Wed 1/31/18	Wed 1/31/18	SDH/HRA	Yes	Telligen SOW 2	execution	3
Milestone-Train SIM TA providers to assist providers to incorporate AMH into clinic and patient workflows	0%	Thu 11/30/17	Sun 12/31/17	SDH/HRA	Yes	Telligen SOW 2	execution	3
Milestone-Train SIM TA providers to assist providers to utilize individual and aggregate reports from AMH	0%	Wed 1/31/18	Wed 1/31/18	SDH/HRA	Yes	Telligen SOW 2	execution	3
Milestone-Incorporate use of AMH tool or SDH questions into MCO screening tools, to include utilization and data work plans	0%	Wed 2/28/18	Tue 5/1/18	SDH/HRA	Yes	Telligen SOW 2	execution	3
Payment Reform: Align Payers in VBP	**45%**	**Thu 1/1/15**	**Wed 8/21/19**	**VBP**	**No**			
Implement ACO Aligned Strategy in	**40%**	**Sat 8/1/15**	**Wed 11/15/17**	**VBP**	**No**			

Task Name	% Complete	Start	Finish	SIM Activity	Milestone	Budget Narrative Mapping	Stage of work	Award Year (1 - 4)
Medicaid (2017 and 2018 Programs)								
Qualify MCO ACO Contracts (Year 2017)	**75%**	**Sat 4/30/16**	**Wed 5/31/17**	**VBP**	**Yes**			
Submit feedback to MCOS (report and or IME Meeting)	100%	Mon 8/15/16	Mon 8/15/16	VBP	Yes	Telligen SOW 3		2
Milestone - IME Leadership Reviews and Qualifies MCO VBP contracts	0%	Thu 3/30/17	Thu 3/30/17	VBP	Yes	Telligen SOW 3		2
Milestone - MCOs to report % of lives in VBP for 2016	0%	Wed 5/31/17	Wed 5/31/17	VBP	Yes	Telligen SOW 3		3
Milestone - Publish 2017 VIS baselines for ACOs and MCOs	0%	Wed 5/31/17	Wed 5/31/17	VBP	Yes	Telligen SOW 3		3
Qualify MCO ACO Contracts (Year 2018)	**0%**	**Thu 6/15/17**	**Fri 9/1/17**	**VBP**	**Yes**			
Milestone - Release the Medicaid APM Contracting Template for 2018	0%	Thu 6/15/17	Thu 6/15/17	VBP	Yes	Telligen SOW 3		3
Milestone - MCO submit 2018 contracts for Qualification (HCP - LAN Level 3A)	0%	Tue 8/1/17	Fri 9/1/17	VBP	Yes	Telligen SOW 3		3
Milestone - MCOs contracts meet qualification	0%	Fri 9/1/17	Fri 9/1/17	VBP	Yes	Telligen SOW 3		3
Milestone - 2018 VIS and TCOC baseline Published	0%	Fri 9/1/17	Fri 9/1/17	VBP	Yes	Telligen SOW 3		3
Update the MCO Incentive Program	**0%**	**Mon 1/30/17**	**Fri 6/30/17**	**VBP**	**Yes**			
Milestone - Share Draft version with MCOs	0%	Mon 1/30/17	Mon 1/30/17	VBP	Yes	Telligen SOW 3		2
Milestone - Publish Final Version of MCO Incentive Program	0%	Mon 5/15/17	Mon 5/15/17	VBP	Yes	Telligen SOW 3		3
Milestone - Update MCO Contracts to reflect new Incentive Program	0%	Fri 6/30/17	Fri 6/30/17	VBP	Yes	Medicaid		3
Achieve at least one Other Payer A-APM by 2019	**0%**	**Mon 5/1/17**	**Wed 11/15/17**	**VBP**	**Yes**			

Task Name	% Complete	Start	Finish	SIM Activity	Milestone	Budget Narrative Mapping	Stage of work	Award Year (1 - 4)
Milestone - Issue MCO Contracting Template with Requirements known to-date	0%	Mon 5/1/17	Mon 5/1/17	VBP	Yes	Medicaid/Telligen SOW 3		3
Milestone - Identify requirements of A-APM program from final rules	0%	Fri 6/30/17	Fri 6/30/17	VBP	Yes	Telligen SOW 3		3
Milestone - Establish plan to update MCO Contract Templates for 2019	0%	Wed 11/1/17	Wed 11/1/17	VBP	Yes	Telligen SOW 3		3
Milestone - Establish Path to seek A-APM Determination	0%	Wed 11/15/17	Wed 11/15/17	VBP	Yes	Telligen SOW 3		3
Manage Quality Tools to support APMs (3M VIS/TCOC Dashboard, Claims and Encounter Data)	**46%**	**Thu 1/1/15**	**Wed 8/21/19**	**VBP**	**Yes**			
Revise VIS Dashboard to Accommodate MCO view	**94%**	**Wed 7/1/15**	**Fri 4/28/17**	**VBP**	**Yes**			
Milestone - MCO Access to the VIS dashboard is available	0%	Fri 4/28/17	Fri 4/28/17	VBP	Yes	3M SOW 2		2
MCOs report Encounter Data to support VIS	**99%**	**Wed 10/14/15**	**Fri 4/28/17**	**VBP**	**Yes**			
Milestone - MCO Encounter data moved into production VIS dashboard	0%	Fri 4/28/17	Fri 4/28/17	VBP	Yes	3M SOW 2		2
Share Raw Claims/Encounter Data with ACOs in Medicaid	**0%**	**Fri 7/28/17**	**Mon 4/30/18**	**VBP**	**Yes**			
Milestone - Update Raw Claims/Encounter Feeds 1st quarter (with each dashboard refresh	0%	Fri 7/28/17	Fri 7/28/17	VBP	Yes	3M SOW 3		3
Milestone - Update Raw Claims/Encounter Feeds 2nd quarter (with each dashboard refresh	0%	Mon 10/30/17	Mon 10/30/17	VBP	Yes	3M SOW 3		3
Milestone - Update Raw Claims/Encounter Feeds 3rd quarter (with each dashboard refresh	0%	Wed 1/31/18	Wed 1/31/18	VBP	Yes	3M SOW 3		3
Milestone - Update Raw Claims/Encounter Feeds 4th quarter (with each dashboard refresh	0%	Mon 4/30/18	Mon 4/30/18	VBP	Yes	3M SOW 3		3
Regular Refreshes of VIS and	**38%**	**Thu 1/1/15**	**Wed 8/21/19**	**VBP**	**Yes**			

Task Name	% Complete	Start	Finish	SIM Activity	Milestone	Budget Narrative Mapping	Stage of work	Award Year (1 - 4)
Total Cost of Care (Online Dashboard) AY2								
Milestone- Refresh the Online Dashboard at least one time during 1st quarter 2016	100%	Thu 3/31/16	Thu 3/31/16	VBP	Yes	3M SOW3		2
Milestone - Refresh the Online Dashboard at least one time during 2nd quarter 2016	100%	Tue 5/17/16	Tue 5/17/16	VBP	Yes	3M SOW3		2
Milestone - Refresh the Online Dashboard at least one time during 3rd quarter 2016 NA: MCO implementation delayed	100%	Mon 10/31/16	Mon 10/31/16	VBP	Yes	3M SOW3		2
Milestone - Refresh the Online Dashboard at least one time during 4th quarter 2016 NA	0%	Sun 4/30/17	Wed 8/21/19	VBP	Yes	3M SOW3		2
Data Sharing Agreements with Delivery System (in VBP) AY1 AND 2	**80%**	**Mon 3/2/15**	**Fri 4/28/17**	**VBP**	**No**			
Milestone - Start Sharing Claims data with Providers in VBP arrangements with MCOs	0%	Fri 4/28/17	Fri 4/28/17	VBP	Yes	Telligen SOW 1.C		2
Milestone - Start Sharing real-time (ADT) alerts with MCOs	0%	Fri 12/30/16	Tue 2/28/17	VBP	Yes	Telligen SOW 3a		2
Milestone - Share Real-time (ADT) alerts with Providers in VBP in Medicaid with MCO	100%	Mon 12/5/16	Mon 12/5/16	VBP	Yes	Telligen SOW 3a		2
Establish TCOC and VIS baselines with Full Medicaid model (Online Dashboard)	**60%**	**Thu 1/1/15**	**Fri 9/28/18**	**VBP**	**No**			**1**
Integrate LTSS/BH into VIS Baseline	**38%**	**Mon 2/16/15**	**Fri 9/28/18**	**VBP**	**No**			
Milestone - Compile a baseline with LTC and Medicare A, B and D data	0%	Fri 9/28/18	Fri 9/28/18	VBP	Yes	3M SOW 2		4
Establish MCO Scorecard Requirements w/Special Populations (tied to 2% withhold)	**41%**	**Fri 1/1/16**	**Mon 4/2/18**	**VBP**	**No**			**3**

Task Name	% Complete	Start	Finish	SIM Activity	Milestone	Budget Narrative Mapping	Stage of work	Award Year (1 - 4)
Milestone - LTC and Duals Data integrated into VIS QMs	0%	Fri 9/30/16	Fri 9/30/16	VBP	Yes	3M SOW1		2
Milestone - 3M to make recommendations for QMs to integrate Special Populations	100%	Thu 6/30/16	Thu 6/30/16	VBP	Yes	3M SOW 4		2
Milestone - 3M to deliver Claims based MCO Special Population Measures - Baseline (pre MCO data)	100%	Wed 9/28/16	Wed 9/28/16	VBP	Yes	3M SOW 3		2
Milestone - 3M to deliver Post MCO Special Pop report (and then with each refresh)	0%	Wed 2/15/17	Wed 2/15/17	VBP	Yes	3M SOW 3		2
Milestone - Share with MCOs the 2% withhold requirements for 2017	0%	Fri 4/28/17	Fri 4/28/17	VBP	Yes	Telligen SOW 3		2
Milestone - Compile report of Special Populations quality for 2017	0%	Mon 4/2/18	Mon 4/2/18	VBP	Yes	3M SOW 4		3
Grow Health Home model with MCOs	**89%**	**Thu 10/15/15**	**Mon 7/30/18**	**VBP**	**No**			**3**
Milestone - Compile Health Home Enrollment for 2016 growth rate	100%	Thu 9/15/16	Thu 9/15/16	VBP	Yes	Telligen SOW 3		2
Milestone - Compile Health Home Enrollment for 2017 growth rate	0%	Fri 7/28/17	Fri 7/28/17	VBP	Yes	Telligen SOW 3		3
Milestone - Compile Health Home Enrollment for 2018 growth rate	0%	Mon 7/30/18	Mon 7/30/18	VBP	Yes	Telligen SOW 3		3
Implement SDH integration and research (with HRA)	**63%**	**Mon 11/30/15**	**Mon 4/30/18**	**VBP**	**No**			**3**
Milestone - Send HRA recommendations to MCOs	100%	Tue 11/29/16	Tue 11/29/16	VBP	Yes	Telligen SOW 3		2
Milestone - AssessMyHealth NCQA Certified as an initial health screening tool	0%	Fri 4/28/17	Fri 4/28/17	VBP	Yes	3M SOW 6		2
Milestone - Share Aggregated SDH and patient confidence data for 2016	0%	Fri 4/28/17	Fri 4/28/17	VBP	Yes	3M SOW 4		2
Milestone - Share Aggregated SDH and patient confidence data for 2017	0%	Mon 4/30/18	Mon 4/30/18	VBP	Yes	3M SOW 4		3

Task Name	% Complete	Start	Finish	SIM Activity	Milestone	Budget Narrative Mapping	Stage of work	Award Year (1 - 4)
HIT and QM Enhancement Planning	**0%**	**Fri 6/30/17**	**Mon 4/30/18**	**HIT Enhancement**	**No**			
Assess Current State of Health IT	**0%**	**Fri 9/29/17**	**Thu 11/30/17**	**HIT Enhancement**	**No**	**IDPH SOW 3**		
Milestone - Conduct a Statewide Assessment of Current HIT Infrastructure	0%	Fri 9/29/17	Fri 9/29/17	HIT Enhancement	Yes	IDPH SOW 3	Planning	3
Milestone - Share Results of HIT Statewide Assessment	0%	Thu 11/30/17	Thu 11/30/17	HIT Enhancement	Yes	IDPH SOW 3		3
Identify System-Wide CQMs	**0%**	**Fri 9/29/17**	**Wed 2/28/18**	**HIT Enhancement**	**No**	**IDPH SOW 3**		
Milestone - Develop Value Propositions & Use Cases	0%	Tue 10/31/17	Tue 10/31/17	HIT Enhancement	Yes	IDPH SOW 3 and Medicaid	Planning	3
Milestone - Conduct a HIT Provider Readiness Survey	0%	Thu 11/30/17	Thu 11/30/17	HIT Enhancement	Yes	IDPH SOW 3	Planning	3
Milestone - Share Results of Provider Readiness Survey	0%	Wed 1/31/18	Wed 1/31/18	HIT Enhancement	Yes	IDPH SOW 3		3
Educate Iowa Providers on the use of Health IT and Analytics to Support VBP and MACRA Alignments	**0%**	**Fri 3/30/18**	**Fri 4/27/18**	**HIT Enhancement**	**No**			
Milestone - HIT and Analytics for VBP presentation on a Statewide Learning Event Agenda	0%	Fri 3/30/18	Fri 3/30/18	HIT Enhancement	Yes	IDPH SOW 3	Planning	3
Milestone - Conduct at least one Webinar on HIT and Analytics for VBP	0%	Fri 4/27/18	Fri 4/27/18	HIT Enhancement	Yes	IDPH SOW 3	Planning	3
Milestone - Publish a Website Resources on SIM pages for HIT and Analytics	0%	Fri 4/27/18	Fri 4/27/18	HIT Enhancement	Yes	IDPH SOW 3	Planning	3
Refine Definition of Quality Measurement for Medicaid Pop	**0%**	**Wed 1/31/18**	**Wed 1/31/18**	**HIT Enhancement**	**No**			
Milestone - Identify a Core Set of CQMs that Align with Population Health and SIM Initiatives	0%	Wed 1/31/18	Wed 1/31/18	HIT Enhancement	Yes	IDPH SOW 3 and Medicaid	planning	3
Pilot Reporting CQMs to Medicaid	**0%**	**Fri 3/30/18**	**Mon 4/30/18**	**HIT Enhancement**	**No**			

Task Name	% Complete	Start	Finish	SIM Activity	Milestone	Budget Narrative Mapping	Stage of work	Award Year (1 - 4)
Milestone - Identify Mechanism that Providers will Use to Report CQMs for APMs	0%	Fri 3/30/18	Fri 3/30/18	HIT Enhancement	Yes	IDPH SOW 3 and Medicaid	Planning	3
Evaluation Plan	**44%**	**Tue 11/24/15**	**Wed 10/31/18**		**No**			
Collaborate with CMMI Evaluator(s) for Cross-State Evaluation	**38%**	**Tue 11/24/15**	**Tue 1/31/17**	**Eval**	**No**			
Milestone- participate in Federal Evaluation Interview and focus group development	100%	Wed 5/18/16	Wed 5/18/16	Eval	Yes	PPC SOW 2		2
Milestone - Review Federal evaluation plan and identify overlap to state evaluation plan	100%	Tue 11/15/16	Tue 11/15/16	Eval	Yes	PPC SOW 2		2
Milestone - Adjust Evaluation Plan based on understanding of Fed Evaluation as necessary	100%	Tue 1/31/17	Tue 1/31/17	Eval	Yes	PPC SOW 2		2
State Evaluation of SIM (outside of Cross-State Evaluation)	**78%**	**Fri 4/15/16**	**Wed 10/31/18**		**No**			
Milestone - Identify and refine study measures and deliverable	100%	Fri 4/15/16	Fri 4/15/16	Eval	Yes	PPC SOW 1	Execution	2
Milestone -Finalize and disseminate data needs to the sources of data (i.e., Iowa Healthcare Collaborative (IHC), Iowa Department of Public Health (IDPH), Iowa Medicaid Enterprise (IME), and Wellmark)	100%	Thu 6/30/16	Tue 8/30/16	Eval	Yes	PPC SOW 4	Execution	2
Milestone - Develop a data clearinghouse	100%	Wed 8/31/16	Wed 8/31/16	Eval	Yes	PPC SOW 3	Execution	2
Milestone -Identify and study (C3) and control counties	100%	Thu 6/30/16	Thu 6/30/16	Eval	Yes	PPC SOW 3	Execution	2
Milestone -Develop questions for statewide consumer/patient survey	100%	Fri 9/30/16	Fri 9/30/16	Eval	Yes	PPC SOW 3	Execution	2
Milestone -Execute data sharing agreement with Wellmark and C3s	0%	Fri 6/30/17	Fri 6/30/17	Eval	Yes	PPC SOW 5	Execution	3
Milestone -Make adjustments to list of measures to be used	0%	Fri 4/28/17	Fri 4/28/17	Eval	Yes	PPC SOW 3	Execution	2
Milestone -Begin contextual analysis	100%	Mon 10/31/16	Mon 10/31/16	Eval	Yes	PPC SOW	Execution	2

Task Name	% Complete	Start	Finish	SIM Activity	Milestone	Budget Narrative Mapping	Stage of work	Award Year (1 - 4)
						3		
Milestone -Investigate and understand BRFSS, YBRS, and birth certificate data	100%	Sat 10/1/16	Sat 10/1/16	Eval	Yes	PPC SOW 3	Execution	2
Milestone -Establish data sharing with IHA	0%	Fri 4/28/17	Fri 4/28/17	Eval	Yes	PPC SOW 1	Execution	2
Milestone -Complete Field statewide consumer/patient survey	100%	Mon 10/31/16	Mon 10/31/16	Eval	Yes	PPC SOW 3	Execution	2
Milestone -Develop provider survey items	0%	Fri 4/28/17	Fri 4/28/17	Eval	Yes	PPC SOW 3	Execution	2
Milestone -Plan Year 2 evaluation activities after review of Year 1 activities and adjustments	0%	Fri 4/28/17	Fri 4/28/17	Eval	Yes	PPC SOW 1	Planning	2
Milestone -Complete Data assessment and planning Year 2	100%	Tue 2/28/17	Tue 2/28/17	Eval	Yes	PPC SOW 1	Execution	2
Milestone - Complete Field provider interviews	0%	Fri 9/29/17	Sat 9/30/17	Eval	Yes	PPC SOW 3	Execution	3
Milestone -Complete first year report: Evaluation of 2016-including selected baseline outcomes of population health, transformation of healthcare, and promotion of sustainability.	0%	Fri 6/30/17	Fri 6/30/17	Eval	Yes	PPC SOW 3	Execution	3
Milestone - Collect and organize information about SIM implementation in AY2 and AY3	0%	Mon 4/30/18	Mon 4/30/18	Eval	Yes	PPC SOW 1 and 3	Execution	3
Milestone - Analyze Statewide Consumer Survey Data	0%	Fri 6/30/17	Fri 6/30/17	Eval	Yes	PPC SOW 3 and 4	Execution	3
Milestone - Conduct Other SIM Provider And Stakeholder Interviews	0%	Thu 8/31/17	Thu 8/31/17	Eval	Yes	PPC SOW 3	Execution	3
Milestone - Evaluation Report on AY2 SIM Activities	0%	Tue 10/31/17	Tue 10/31/17	Eval	Yes	PPC SOW 3	Execution	3
Milestone - Conduct Interview of C3 Project Staff	0%	Sat 9/30/17	Sat 9/30/17	Eval	Yes	PPC SOW 3	Execution	3
Milestone - Conduct Interview of C3 Participants (Consumers)	0%	Thu 11/30/17	Thu 11/30/17	Eval	Yes	PPC SOW 3	Execution	3

Task Name	% Complete	Start	Finish	SIM Activity	Milestone	Budget Narrative Mapping	Stage of work	Award Year (1 - 4)
Milestone - Compile and Analyze Data for Report on AY3 SIM Implementation Activities	0%	Mon 4/30/18	Mon 4/30/18	Eval	Yes	PPC SOW 3	Execution	3
Milestone - Evaluation Report on AY3 SIM Activities	0%	Wed 10/31/18	Wed 10/31/18	Eval	Yes	PPC SOW 3	Execution	4
Milestone - Complete Data Acquisition	0%	Fri 6/30/17	Fri 6/30/17	Eval	Yes	PPC SOW 1,4,5	Execution	3
Milestone - Goal Evaluation Report Part 1 Baselines CY2015	0%	Tue 10/31/17	Tue 10/31/17	Eval	Yes	PPC SOW 3	Execution	3
Milestone - Goal Evaluation Report Part 2 Baselines CY 2015	0%	Mon 4/30/18	Mon 4/30/18	Eval	Yes	PPC SOW 3	Execution	3

Award Year 2 Milestones Not Completed (Excludes AY 2 Milestones targeted to be complete by April 30, 2017):

Delivery System Reform			
Milestone	% Complete	Target Finish Date	Why Not Complete
Annual Report on progress for SIM TA Projects	0%	5/30/17	With the extension for Award Year 2, this task is now targeted for May
50% of Initial Health Screenings use a tool that share SDH and patient confidence data with a PCP	0%	NA	The implementation of managed care shifted priority of this task. A new set of milestones have been proposed for AY3
Payment Reform			
Refresh the online Quality dashboard during 4th quarter	30%	5/30/2017	The efforts to collect, validate, and analyze the encounter data has taken longer than anticipated. Progress is being made, but the state is not going to complete this task in award year 2.
LTC and Duals data integrated in VIS QM	20%	9/28/18	The state pushed the priority of testing the duals and LTSS data to award year four to focus on the establishment of ACO quality and TCOC for award year 3.
3M dashboard updated with MCO scorecard	0%	NA	The state spent resources in AY2 to develop Special Populations measures and it was determined that it is not necessary to move the measures into an online dashboard at this time and will share special population reporting with MCOs through run charts created in Excel. (See AY3 Ops Plan Section B Narrative).
Evaluation			
Complete field Provider Interviews	0%	9/30/17	C3 provider interviews will go into held February 3, 2017. The rest of the provider and stakeholder interviews will be fielded in the late spring/summer 2017.
Execute Data Sharing Agreements with Wellmark and C3s	50%	6/30/17	The activity was identified as a risk (see risk log) and has proven to be challenging. The Evaluation has adjusted to not include Wellmark in all of the outcome measurement based on the level of data they are able to use.

Section B: SIM Policy and Operations

1. SIM Stakeholder Engagement & Governance

a. Management Structure and Decision-Making Authority

The Iowa SIM Test Grant operates under executive sponsorship from the Iowa Governor's Office, contracted through the Department of Human Services (DHS). The Director of the DHS is the Executive Chair accountable for the implementation of the grant project, and all activity specifically funded by the grant is accomplished via contracts through the DHS. Oversight of each grant contract is managed through the Contracts Management Office within the Medicaid Division of the DHS. Staff from each contract meets regularly with SIM project managers to review, adjust and update project milestones, action items, and risks. Items that need escalation are compiled and reviewed with IME/DHS/IDPH Leadership on a regular and as needed basis. The Director of the DHS reports to the Governor's Office as necessary to ensure the Office maintains a proper strategic understanding of the project as it matures. In this way, the Governor's Office can provide input and direction for synergy with other state priorities and initiatives. The DHS engages legislators on SIM activities as necessary, and Senate File 505 requires DHS to report to a legislative committee on SIM activities at least annually.

The Strategic Implementation Team is the small, project governance body made up of leaders from the payer, provider and public health communities under the direction of the DHS Executive Chair. The team ensures alignment with key initiatives driving healthcare transformation and formulates the operational use of grant funding. Members are expected to advise and take action within their constituencies to help achieve the goals of the SIM Initiative. The team directs SIM Implementation Partners that are under contract and responsible to carry out various aspects of the daily operations of the SIM grant. The SIM project team defines and manages the operational plan for SIM, and acts as a coordination hub on project execution. The roles and rationale for each of these members are found in the Stakeholder Engagement plan, Appendix D of this document.

Members of Strategic Implementation Team:
Chuck Palmer (DHS): Chair
Mikki Stier (IME)
Gerd Clabaugh (IDPH)
Tom Evans (IHC/Provider)
Laura Jackson (Wellmark/Payer)
Linda Miller (Department of Aging)
Patrick Schmitz (MH/Disabilities Provider)

Implementation Partners:
Iowa Department of Human Services - DHS
Iowa Medicaid Enterprise - IME
Iowa Department of Public Health - IDPH
Iowa Healthcare Collaborative - IHC

3M
Telligen
University of Iowa Public Policy Center - PPC
Wellmark
Medicaid MCOs: Amerigroup, AmeriHealth Caritas and United Healthcare*

**Each of Iowa's three Medicaid MCO's have contractually committed to supporting the activities of the SIM grant, both in a general way as well as with specific requirements relating to patient assignment, value based purchasing (VBP) thresholds and aligned quality measurement. In award year 3, the MCOs have been given parameters and timeframes for establishing aligned VBP contracts, including quality targets maintained through the Medicaid Agency. In addition for year 3, the MCO's also have capitation-withhold-based performance incentives tied to the same measure of quality required of the delivery system (the Value Index Score) along with total cost of care targets that are necessary to qualify for the incentive payout.*

For Wellmark and any other payers that may join along the way, the SIM project is better described as an "opportunity" rather than a "commitment". The project structure includes an ongoing, statewide strategic conversation about how Iowa's healthcare delivery system functions now and moving into the future; it is the opportunity to inform decision points and help set statewide priority moving ahead as the project unfolds and the transformation matures.

b. Leveraging Regulatory Authority

In addition to the DHS, another cabinet level agency, the Iowa Department of Public Health (IDPH) is also embedded within the grant and its leadership structure. The DHS has a long history of partnership with the IDPH through various contracting activities including the efforts of SIM back to the original SIM Design grant phase. Together, the Directors of the two agencies work in partnership with the executive and legislative branches to ensure the goals of SIM are understood and integrated into Iowa's strategic vision and legal framework.

The SIM project represents a statewide, funded opportunity to have payers, providers and public health collectively navigate emerging, national payment reforms aimed at moving from volume to value. The project itself *is* the primary "policy lever" used to identify mutual points of interest within this new context and maximize the effectiveness of a statewide response to gaining control of healthcare costs as financial pressures demand change. In essence the project assembles a structure to pursue the triple aim in a coordinated way statewide even as the "known unknown" of significant national change around healthcare coverage, payment reform strategy and financing looms. As identified through the project, both the DHS and the IDPH have the authority to support, oppose and submit legislative packages and update the Iowa Administrative Code to ensure SIM activities are legally supported as necessary, but it should be noted that Iowa typically takes a more grass roots approach to fostering such change.

Levers such as MCO contract requirements, aligned quality measurement and patient attribution are already in place and supported by technical assistance and community infrastructure. Moving into the future, Iowa looks to build additional policy leverage points, such as common, identified clinical quality measure sets and collection infrastructure and related analytic

capability to enhance VBP, along with a push to develop a statewide Health Risk Assessment with the goal of pushing VBP measurement more directly into social determinants of health data.

c. Stakeholder Engagement

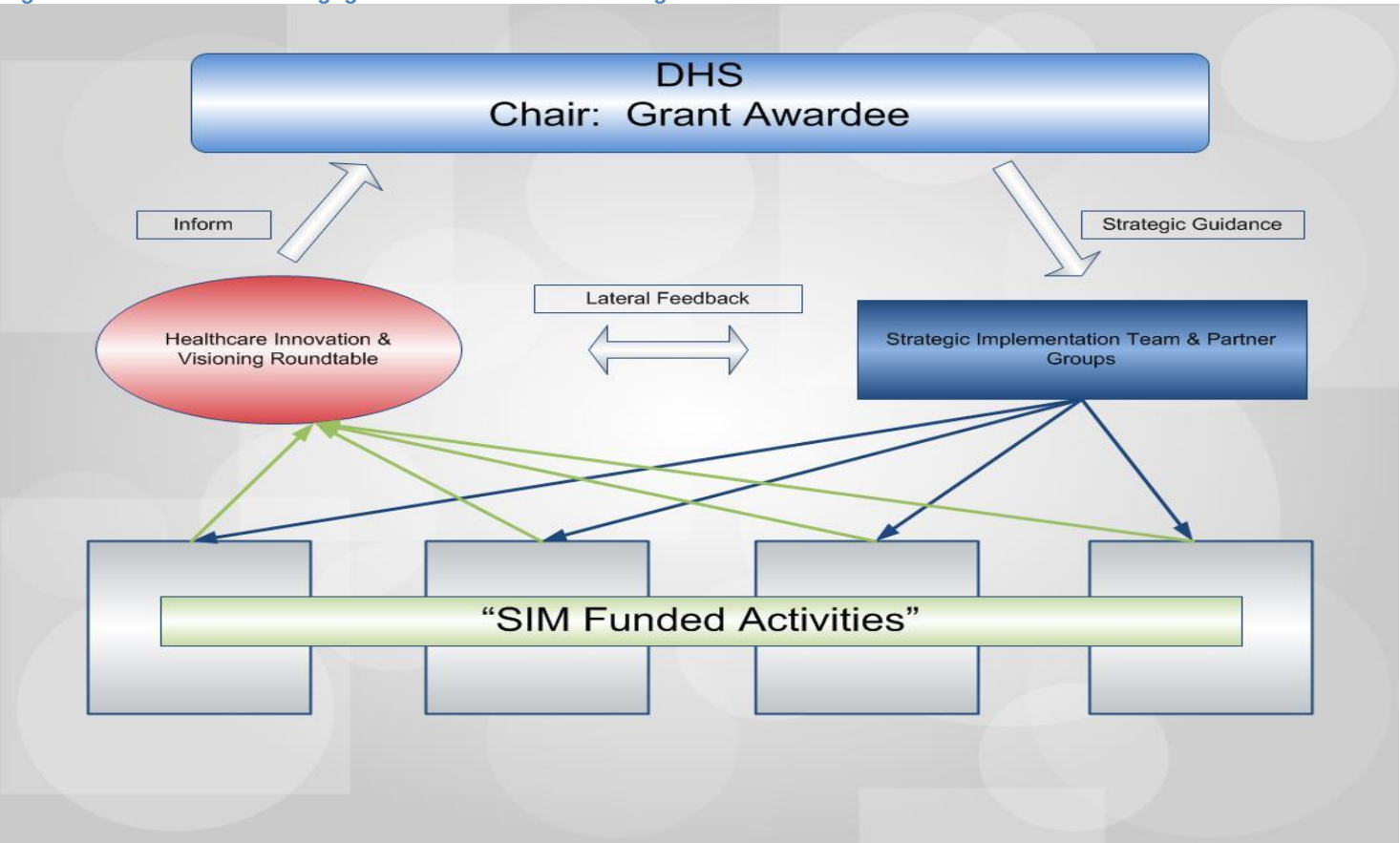
A new Healthcare Innovation & Visioning Roundtable is designed to bring together willing and influential senior leadership bolstered by experts from the constituency most acutely impacted by the emerging risk based payment reforms and therefore, most immediately accountable for making change in clinical and community practice actually happen across the state. The purpose of the group is to identify and prioritize elements necessary for reform, such as specific payment models, infrastructure support, and policy or regulatory shifts necessary to fuel progress. The group evaluates and feeds the ongoing SIM project and related efforts, and also forms a community of practice environment that collaborates around emerging best practice, common problem areas and regional differences. The roundtable is also charged with identifying and building specific workgroups essential for planning more granular tasks deemed necessary as the work evolves, such as: informing specific, new quality measures to be used in statewide VBP efforts.

The work and makeup of the Roundtable will be expanded at times as specific needs are identified to be addressed within the larger project. This design acknowledges that not only will the project mature and change over time which will call for consideration of new strategic elements (and re-consideration of old), but it also allow for leveraging key expertise and advocacy *at the right time* within the life cycle of a such a large, multifaceted project (for example: addressing rural context, small practices, and the interplay of long term care, behavioral health, and how children fit into population health quality measurement). A Roundtable leveraging workgroup support as necessary keeps consensus manageable and lends project agility, while still allowing for key constituent influence. Once a workgroup is identified by the Roundtable and implemented, they consider specific assignments and report back. The workgroups also form a sort of “information clearinghouse” as common pain points, emerging innovations and solutions ideas are discussed by members. The roles and rationale for each of these members are found in the Stakeholder Engagement Plan, Appendix C of this document.

Initial Organizations of Healthcare Innovation & Visioning Roundtable:

DHS Council
Iowa Health+
Iowa Insurance Division
Mental Health and Disabilities Commission
Unity Point Health Partners
University of Iowa Health Alliance
Iowa Department of Public Health
Iowa Healthcare Collaborative
Iowa Medicaid Enterprise
Mercy Health Network
University of Iowa
Wellmark Blue Cross Blue Shield

Figure 4: SIM Stakeholder Engagement and Governance Diagram



As indicated in figure 4 above, the ultimate decision making authority related to the grant itself is the Iowa DHS Chair, Director Charles Palmer, who directly reports to the governor's office. He will be the arbiter in any case if there is substantial disagreement over direction or priority. However, generally speaking, the model is about establishing a process to find areas of mutual interest and agreement, and then to build off that consensus. This mutual interest factor is increasingly possible because the intensifying, national forces pushing toward healthcare value apply pressure to all parties: payer, provider and public health. The project includes a statewide, strategic conversation about the future of Iowa's healthcare delivery system, and the related workgroups inform decision points, and help set priority moving ahead.

In addition to the creation of the new Roundtable, Iowa has already been busy engaging with providers to educate about the changes being made to the health care system through a series of statewide SIM Learning Communities hosted by the Iowa Healthcare Collaborative (IHC). Technical Assistance to the delivery system is on the SIM Funding Activities and new in Award Year 3 is an emphasis on engaging providers working on APM programs in Iowa.

A final, important piece of Governance and Stakeholder Engagement within the SIM is acknowledging the importance of Health Information Technology (HIT) within the transformation process. The ability to leverage data is key to advancing individual care coordination as well as deriving quality to measure population health under accountable care strategies. Currently the

Iowa Health Information Network (IHIN), which is Iowa's statewide Health Information Exchange, is in the process of moving from state government (through the IDPH) to non-profit status; we expect that to be completed in March of 2017. The IDPH is lead in HIT planning on the project and represented on both the Strategic Implementation Team and the Healthcare Innovation & Visioning Roundtable to ensure the interests of IHIN and consideration of HIT are well represented as SIM matures through award year 3.

2. Health Care Delivery System Transformation Plan

a. Payment Model(s)

Payment Models for the Iowa SIM are focused on APMs in the form of ACO programs executed by Medicaid and Wellmark. Although there is significant activity with Iowa providers in contracting and aligning with the Medicare APMs programs, like the Medicare Shared Savings or Next Generation ACOs models specifically, this section is focused on the work that Medicaid and Wellmark are doing to align APM programs with the Medicare Quality Payment Program and the path to develop and implement an Other Payer Advanced APM in Iowa by the end of the Iowa SIM grant.

Payment reform to support delivery system transformation is aligned across the Medicaid MCOs as it is embedded into the state's managed care contracting design. While ACO payments flow from the MCOs, the primary measure of quality scoring (the VIS) and total cost of care (TCOC) are calculated through the state and are the basis upon which performance related payments are made. Engaging in risk based contracts with ACOs allows MCOs to shift some care coordination responsibilities to ACOs. With large segments of their populations accounted for by the ACOs, the MCOs can focus more attention on the management of special populations and certain disease management areas where they bring tools, expertise and prior success. The simple diagram below shows this flow from the state through the MCO and down to the ACO.

Figure 5: Flow of Medicaid's Aligned ACO Strategy through the MCOs

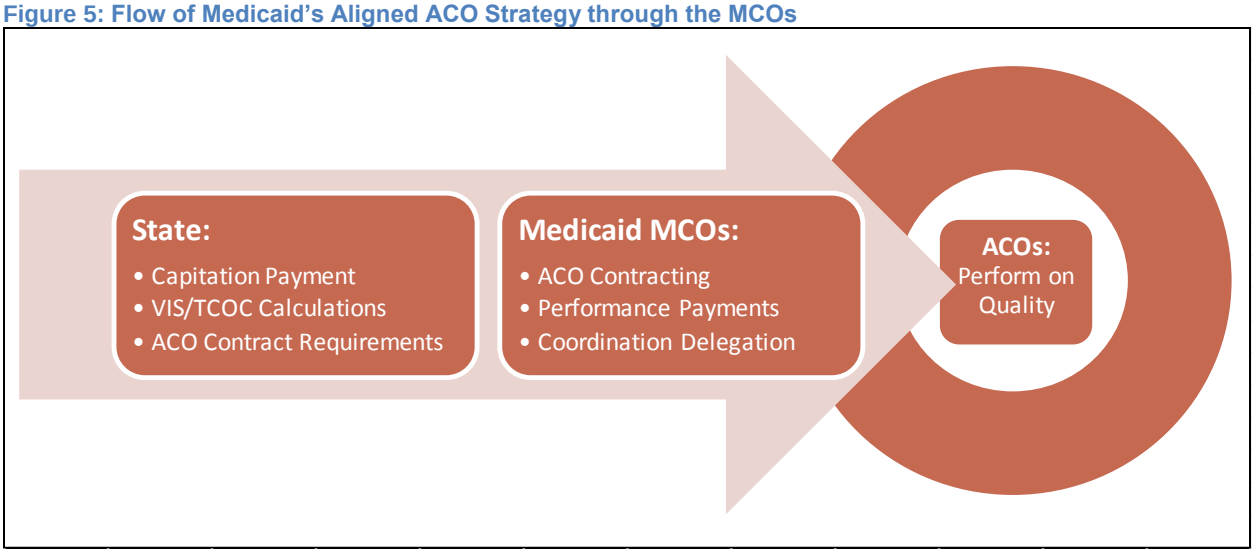


Figure 6: Table of Payment Reform and Delivery Reform Linkages

Value Based Payment Models (APMs)	*Financial Risk Arrangements*	*Quality Measures*	*Attribution Methodology*	*Service Delivery Model linkages*	*Current Status*	*Baseline Data Reported for 2015*
Medicaid ACO	Starting with SS only (Category 3A)and moving to SS/SL (Category 3B by 2019) By 2018 Provider group must achieve both QM and TCOC thresholds to receive SS	Starting with VIS (claims based measures) moving to VIS and Clinical Quality Measures by 2019 to achieve an A-APM status	Rolling Attribution (based on PCP assignment or plurality of visits). PCPs participate in APM by their Tax ID designation to an ACO	• Healthcare Performance Improvement (TA) • SWAN (HIT Improvement) • C3s/Population Health Improvement • Health Homes • TCPI • HRAs	• Started in 2014 with direct contracts with Medicaid and 5 healthcare systems. • In 2016 during the switch to an MCO environment, focus is on executing contracting with those original 5, so • Some MCOs have engaged other systems, with the potential to expand the original Medicaid footprint	Lives Covered • 64,599 out of 592,711 = 10.9% • Target = 50% Providers Participating: • 2,740 out of 6,136 = 44.7% • Target 50% Provider Organizations Participating: • 40 out of 327 = 12.2%
Wellmark ACO	SS/SL (Category 3B) Provider group must achieve both QM and TCOC thresholds to receive SS/SL	Starting with VIS (claims based measures) moving to VIS and Clinical Quality Measures to achieve an A-APM status by 2019	Rolling Attribution based on PCP (assignment or plurality of visits). PCPs participate in APM by their Tax ID designation	• Healthcare Performance Improvement (TA) • SWAN (once expanded to other payers) • C3s/Population Health Improvement • TCPI	• Started in 2012 has grown to include 15 healthcare systems in Iowa	Lives Covered • 494,471 out of 1,681 = 32% • Target 50% Providers Participating: • 1,993 out of 3,746 = 53.2% • Target maintain at least 50%

The above chart is further detailed in the narrative below, specifically around the design elements of the payment models, delivery models, attribution methodology, risk adjustment used for TCOC and Quality Measures and benchmarking and the status of implementation.

The Medicaid ACO program consists of the following guiding principles:

- **Establish a contracting framework, carried out by the MCOs** that both aligns with Wellmark on quality and with MACRA on A-APM requirements
- Establish an aligned statewide definition of quality healthcare linked to VBP strategies.
- Expand the current method to collect and report back quality results to healthcare systems and health plans to include clinical quality measures
- Provide a glide path for all providers and health systems to aggressively transform into value-based organizations that get paid based on quality and cost (value)

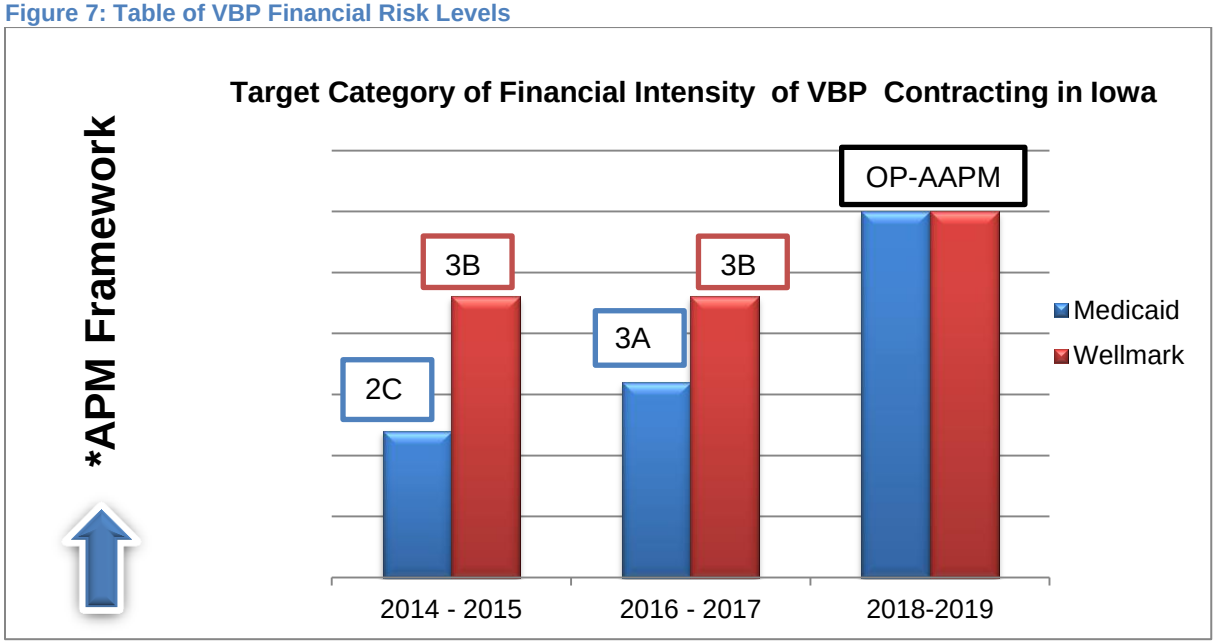
Building off the LAN key principles of APM development, Iowa will seek guidance from the Healthcare Innovation and Visioning Roundtable to ensure our programs are advancing statewide strategies for sustainable health by fostering common agreement around:

- Technical Assistance to the Delivery System
- Health IT Enhancements
- Accountable Communities
- Empower Patients to be Partners
- And Fiscal Models (Shift to Population–Based Payments, Incentives Should Reach Providers
- Payment Models linked to Quality

Iowa is committed to developing VBP strategies that align payers across the state, ensuring SIM activities have the greatest reach and improve care for all Iowans. Most of the work is specific to developing ACO models. Although Iowa recognizes that not all providers will engage in an ACO program, our goal is to enroll 50% in an ACO model by the end of calendar year 2019. Section C.1 describes how Iowa will use payment reform with ACOs as a primary driver of healthcare delivery system transformation. Ingrained in the SIM is the goal to increase participation within VBP arrangements (number of providers and number of covered lives). An additional goal is to increase the intensity (increase financial risk and reporting of quality) of those VBP contracts in Iowa to align with MACRA by offering Other Payer Advanced APM models to providers by 2019.

Below, Figure 7: Table of VBP Financial Risk Levels, depicts both the current state of ACO contracts in Iowa with Medicaid and Wellmark Blue Cross, Blue Shield and the projected increase in financial risk needed to meet the CMS requirements of Advanced Alternative Payment models (A-APMs). What the table does not display is the level of APM and A-APM activity in our state for Medicare. Most of the large systems in Iowa participating with Medicaid and Wellmark are also participating with Medicare in an ACO that is an APM or A-APM program.

Figure 7: Table of VBP Financial Risk Levels



**Aligns with HCP LAN Alternative Payment Model Framework*

Wellmark started VBP with an ACO shared savings program in Iowa in 2012. Today, they contract with 15 different health systems in Iowa that links payment to quality with shared saving /shared loss (SS/SL) arrangements. Their contracts are classified as category 3B according to the HCP LAN Alternative Payment Model Framework. In 2015, Wellmark classifies 32% of their payments to Iowa providers are in a Category 3B program. Wellmark reports 53% of their Primary Care Provider network are under a VBP contract.

Definitions for Figure 6

1. Category 2C = Rewards for Performance
2. Category 3A = APMs with Upside Gainsharing
3. Category 3B = APMs with Upside and Downside Gainsharing
4. Other Payer Advanced APM (OP AAPM) = A Category 3B APM that also meets the guidelines of MACRA around Certified EHR use, Clinical

Medicaid started VBP with five ACO contracts with eight health systems classified as a category 2C according to the HCP LAN Alternative Payment Model Framework. The Medicaid contracts were linked to quality, but did not include SS/SL arrangements. In 2015, Medicaid reported 30% of their payments to Iowa providers were classified as a category 2C and 45% of their Primary Care Provider networks were under an ACO contract. Those contracts ended in 2015 with the introduction of Managed Care Organizations (MCOs) starting April 1, 2016. These organizations are currently responsible for approximately 95% of Medicaid-eligible lives.

Medicaid requires each MCO to implement VBP programs directly with health systems. Each MCO must include the common quality measure set VIS, and must track Total Cost of Care. The MCOs are contractually required to have 40% of their covered lives in a qualified ACO program by 2018.

Today, all three MCOs are actively working with health systems to engage them in ACO contracting for the Medicaid population. All of the original five Medicaid health systems are engaged in contract negotiations with MCOs, some have signed contracts or signed commitments to engage in the ACO programs in the coming months. One MCO has started to work with health systems that Medicaid had not previously engaged, moving beyond the footprint Medicaid established in 2014 and 2015. The MCO contracts have SS components linked to quality and can be classified as category 3A. However, Medicaid is working with each MCO to strengthen alignment in 2017 with the requirements of VBP [3] as defined in Iowa Medicaid's SIM initiative by approving each ACO contract and developing a Medicaid Contract Template that each MCO will use in 2018. By using the standard contract template, Medicaid is working toward each MCO using the same quality framework[4], linking to a Total Cost of Care (TCOC) budget that is consistent across the three MCOs, and introducing requirements that align with the MACRA QPP. This will increase provider confidence in the programs offered by each MCO. To that end, Iowa is in the process of establishing a Medicaid APM Quality Payment Guide. A draft of this guide is found in Appendix F.

Below table illustrates how aligning Risk Based Contracting across payers allows an ACO to get to scale. The **numbers are estimates only** for the purpose of demonstrating how a health system can get to scale with payers aligning their risk based contracting requirements.

Figure 8: Iowa Health Systems Getting to Scale

	Payer Mix by ACO	Percent of Covered Lives in ACO Contract by Payer			Scale =Total % of covered lives in VBP
		Medicare	**Medicaid**	**Wellmark**	
County Hospital ACO **(urban setting)**	30% Medicare 55% Medicaid 10% Wellmark 5% Other	NA	35% (signed w/ two MCOs)	NA	35% (2 total VBP contracts)
FQHC ACO **(9 FQHCs, spread across the state)**	35% Medicare 50% Medicaid 10% Wellmark 5% Other	NA	50% (signed with all 3 MCOs)	NA	50% (3 total VBP contracts)
Hospital Based 1	35% Medicare 15% Medicaid 45% Wellmark 5% Other	20% (MSSP Track 1)	15% (signed with all three MCOs)	40%L)	75% (5 total VBP contracts)
Hospital Based 2	35% Medicare 15% Medicaid 45% Wellmark 5% Other	25% (Next Gen)	15% (signed with all three MCOs)	40% (SS/SL)	80% (5 total VBP contracts)
Teaching Hospital Based	35% Medicare 15% Medicaid 45% Wellmark 5% Other	20% (MSSP Track 1)	7% (signed w/one MCOs)	30% (SS/SL)	57% (3 total VBP contracts)

[3] https://dhs.iowa.gov/sites/default/files/VBP_Models_Definition_and_Qualifying_Criteria_for_Determining_Eligible_Models.pdf
[4] See section 2(b.) of this document Quality Measure Alignment for details on VIS

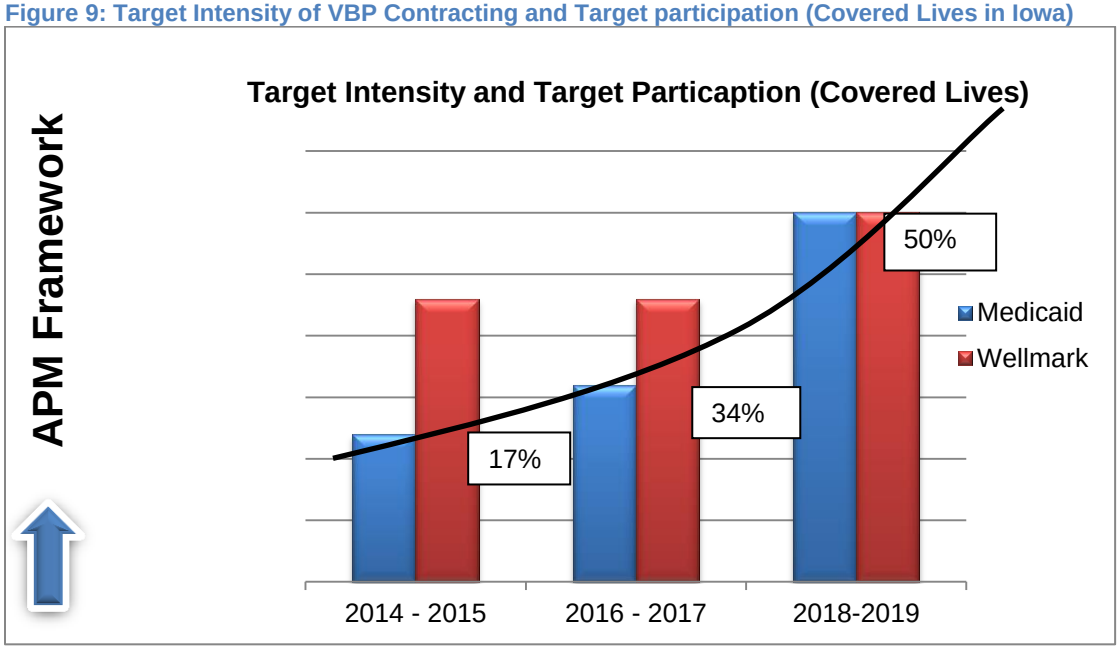
As the ACO groups increase contracting with payers, they may also increase the number of Tax Identification Numbers (TIN) s participating in the ACO contract, which will also positively impact the number of covered lives. As these contracts begin to have similar financial risk levels, aligned quality measures, similar reporting requirements etc., the more a provider group can implement core process improvements that impact their success in all value-based programs.

Iowa will further improve alignment in Medicaid VBP with the Medicare QPP. This will be accomplished through development of a glide path to collect and incorporate clinical quality measures linked to payment during 2017 and 2018. This will enable the 2019 VBP program to meet the A-APM requirements set by MACRA legislation[5]. Both Medicaid and Wellmark are evaluating the requirements of pursuing this goal and recognizing that the collection of the additional clinical data components within the Quality Payment Program (QPP) will require infrastructure and supports across payers. Iowa believes that pursuing an Other Payer A-APM model aligns with the vision of SIM by helping providers get to scale with a payment model that truly transforms the system to a value-based system, instead of a volume-based system.

SIM is also working on delivery system reform by promoting tools, pursing advancement of HIT, offering technical assistance, and implementing population health strategies that aim to improve healthcare delivery (more details on delivery system reform are below). An A-APM model also supports many Iowa providers to achieve the Qualified Participant (QP) threshold of the Medicare A-APM program to receive a 5% bonus for reporting year 2019 and beyond. As described in Figure 9: Target Intensity of VBP Contracting and Target participation (Covered Lives in Iowa), as Iowa increases the financial intensity of VBP contracts (using the APM Framework), the number of covered lives (indicated by the black line) under VBP contracts also increases.

[5] See the HIT Improvement Plan, Appendix D of this document for details on the development of the glide path.

Figure 9: Target Intensity of VBP Contracting and Target participation (Covered Lives in Iowa)



Iowa aims to increase the intensity of APM contracts, increase participation in the number of covered lives under those contracts, and the number of providers participating in APMs to align and support MACRA.

AY3 Activities:

- **Qualify MCO 2017 contracts that meet the 40% requirement**
- **Finalize the MCO Incentive Program to align with VIS and TCOC requirements**
- **Publish the 2017 and 2018 Baselines scores for VIS and TCOC**
- **Release the Medicaid APM Contract Template for 2018**
- **Start the process with CMMI, for an Other Payer A-APM Determination**
- **Engage in HIT Planning to incorporate clinical quality measures into ACO contracts**
- **Establish a voluntary reporting strategy for clinical measures**

Section C of this document describes the details (milestones, actions steps, and timelines) related to **how** Iowa will align payers in the ACO programs and increase the number of covered lives and the number of financial risk arrangements in Iowa.

Total Cost of Care (TCOC)

Medicaid is using a TCOC methodology developed by 3M that looks at all claims/encounter data, risk categories, stop loss, and persistent weighting logic to establish an expected PMPM TCOC. The TCOC calculation is updated on a Value Index Score dashboard which is refreshed regularly and is made available to providers and MCOs participating in VBP. Wellmark BCBS uses a similar model with their TCOC calculation in the VIS dashboard.

TCOC is calculated for Medicaid in the VIS dashboard as the sum of all allowed amounts for all medical claims for a member. These allowed amounts are summed regardless of the

submitting provider's group, system affiliation, or site of service. It is designed as a calculation to represent the true cost of medical claims accumulated for an individual for a specified 12- month timeframe. All inpatient, outpatient, professional, and prescription claims are included in the TCOC calculation for the standard Medicaid population.

TCOC is represented as a percent of the expected cost by aggregating information for all members included in an age, gender, and Clinical Risk Group specific cohort to establish an expected average TCOC. Each member of a given cohort is compared to the average TCOC for the entire cohort to establish a percent difference from the expected TCOC. This variance from expected is calculated at a member level but is also aggregated to attributed physicians, physician groups, clinics, and ACOs within the dashboard.

Figure 10: 3M Dashboard Total Cost of Care Display

Total Cost of Care

Key Performance Measure	Rolling 12 months 2014/06-2015/05
Variance from Budget (PMPM $)	($15.72)
Variance Inpatient (PMPM $)	($0.41)
Variance Outpatient (PMPM $)	($18.97)
Variance Provider (PMPM $)	($4.11)
Variance Rx (PMPM $)	$7.78

There are some exceptions to the TCOC calculations in the dashboard for a subset of the IME member population to ensure accurate and fair reporting of TCOC calculations. Any member listed as COB, having a coordination of benefits, in which a secondary payer is responsible to pay claims for that member, is currently excluded from influencing the expected calculations of TCOC within a clinical cohort.

In an effort to include Long Term Care (LTC) members in an institution, the analytic vendor 3M is currently reviewing the Medicare Dual Eligible members as well as the entire costs of Long-term Care members. Once the review and quality checks have been completed, the LTC data is expected to be included in the 2018 TCOC baseline data due at the end of 2017.

Stop Loss is another tool Medicaid included in the calculation of TCOC to account for outliers that may skew the TCOC performance from a provider or system perspective. For the standard population, Medicaid has selected a $150,000 per individual stop loss level. This stop loss applies to the creation of expected TCOC calculations as well as the comparison of actual costs to expected costs. When the state includes the LTC data into the TCOC calculation, the customized stop loss levels based on member type will be applied. Members receiving LTC services will have a separate customized stop loss level to account for cases that qualify as outliers.

In 2016, the state began using a persistent weight set embedded in the dashboards that allows for time series comparisons of TCOC performance. This persistent weight set was created using 3 years' worth of claims information to establish expected TCOC ratios for all clinical cohorts. The weights were maintained for a defined period of time in order to accurately assess the movement of TCOC performance over time. However, due to the implementation of

Managed Care there was a delay in processing MCO encounter data. The TCOC performance for 2016 will be calculated in the coming months as the system recovers from this delay.

As part of our annual reporting requirements to CMMI, Iowa will calculate a Total Cost Index (TCI) using the CMS supplied measure from the Model Performance Metrics tab. This measure will be calculated by our state-selected evaluators (the University of Iowa's Public Policy Center) using Medicaid data. Upon securing a complete set of Iowa Medicare data (Medicare A, B and D that includes duals and nondual Medicare beneficiaries) and a complete set of data for other commercial payers, Iowa will report TCI over the duration of SIM.

Iowa does not have an All Payer Claims database. The state does have a limited all- payer claims data set for inpatient and outpatient events within a hospital setting. While this will not help us calculate TCOC or TCI, it will assist in measuring other aspects that inform delivery system transformation during our model test. The Inpatient Outpatient data base (IPOP) will be utilized by the Iowa Healthcare Collaborative as they develop community scorecards and performance improvement processes for C3s and health care systems as a technical assistance tool.

Iowa is interested in collecting a Medicare population claims data set (Part A, Part B, and Part D) and processing it using VIS to establish quality scores for the purpose of the SIM ongoing evaluation. To date, the state has been granted access to Iowa Medicare and Iowa Dual data and is in the process of staging and sharing that data per the data use agreements established.

b. Service Delivery Models:

Iowa began the conversation about delivery system reform in 2008 with house file 2539, and legislatively created the Patient Centered Medical Home Advisory Council[6]. This council is still in existence today, but has been renamed the Patient Centered Health Advisory Council. The council is well attended by providers and advocates and activities of SIM are regularly communicated to this group. Their mission is to promote community care coordination and advance the patient-centered transformation of the health care system, which will improve care and reduce cost. The overarching goals are:

- Convening stakeholders
- Building relationships and partnerships
- Streamlining efforts
- Presenting to and offering technical assistance to a variety of organizations including Local Public Health Agencies and Maternal and Child Health grantees to prepare for the changing health care environment.

In 2012, Iowa Medicaid was the 6th state in the nation to receive approval of a Health Home State Plan Amendment which offers a per member per month payment to qualifying providers to deliver health home services, including comprehensive care coordination to individuals with chronic conditions, known as the Chronic Condition Health Home (CCHH). Iowa Medicaid went

[6] http://idph.iowa.gov/ohct/advisory-council

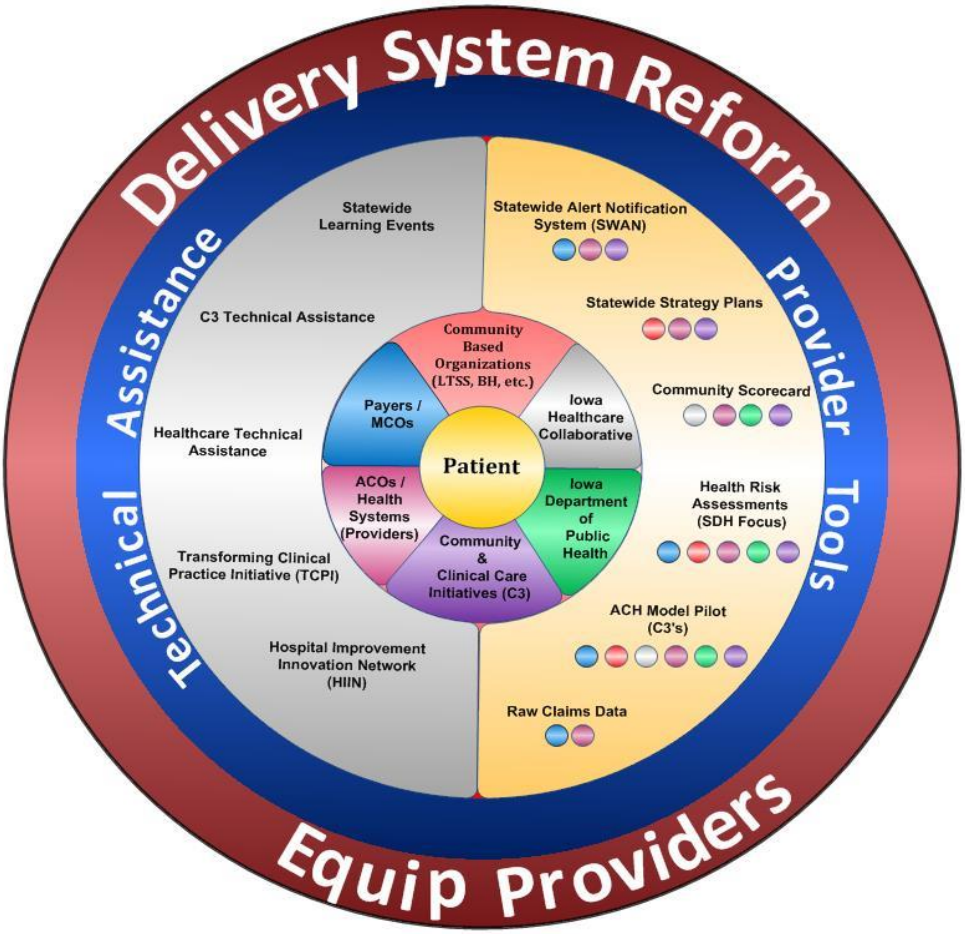
on to develop a second Health Home program for individuals with a Serious and Persistent Mental Illness (SPMI) known in Iowa as the Integrated Health Home (IHH). Together these two programs **promote comprehensive care coordination** by adopting the PCMH model in the primary care setting. Today roughly 20% of primary care has obtained an NCQA PCMH Recognition and other PCMH programs are recognized in Iowa as well. Although Iowa Medicaid believes the Health Home program has room to grow and spread, the SIM grant transformation efforts focus reform efforts that support providers in APM models that build off the base understanding and adoption of PCMH.

Iowa's SIM augments the comprehensive care coordination-focused projects that have been established, continuing to build infrastructure based on those supportive foundations. The AHRQ provides Mechanisms for Achieving Care Coordination (Domains) in their *Care Coordination Measures Update*[7]. Those domains include communication, facilitating transitions, assessing needs and goals, creating proactive plans of care, supporting self-management goals, linking to community resources, aligning resources with patient and population needs, and establishing accountability or negotiating responsibility. As broad approaches, AHRA notes medication management, Health IT-enabled coordination, and teamwork focused on coordination. In this Operational Plan, you will find strategies related to these domains and broad approaches. Iowa's models for care coordination have been established. This plan represents expansion of those efforts and strategies to secure sustainable adoption of delivery system changes based on coordinated care.

Delivery system transformation activities for SIM include supporting and equipping the system to adopt an ACO payment model and sustain its use. SIM provides technical assistance and tools to assist with this transformation. Together, these components represent the Delivery System Reform Model for transformation as pictured in Figure 11 below. Delivery System Reform and Payment Reform working together align incentives and motivates systems to engage in transform. Figure 6 in this document links delivery system reform components to the ACO payment reform model being tested in Iowa with Medicaid and Wellmark.

[7] Agency for Healthcare Research and Quality. (June, 2014). *Care coordination measures atlas update.* Retrieved from https://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/atlas2014/index.html

Figure 11: Delivery System Reform Model



1. **Statewide Alert Notification (SWAN):**
   SWAN is an example of an innovation that supports providers in APM models and MCOs in managing the health of their population. The SWAN system is new infrastructure[8] established by SIM to aid providers engaged in VBP to improve care coordination for members during critical transitions (admissions, discharges, and transfers). Improved coordination during transition has proven to reduce readmissions and improve outcomes[9] by catching medication errors and synchronizing care plans from multiple specialty providers. Getting the right information to the right provider in a timely manner also reduces unnecessary spending within the healthcare system and helps providers focus on population health strategies like reducing preventable readmissions, reducing medication errors and improving follow-up after inpatient visit measures.

   How it Works:
   Providers and MCOs submit a monthly list of Medicaid members they are managing. The SWAN system produces a daily digest of members from these lists that had an Emergency Room Discharge, Inpatient Admission, or an Inpatient Discharge from one of the participating

[8] Established in Iowa in December 2015 for Medicaid lives

[9] Coleman EA, Parry C, Chalmers S, Min S. The Care Transitions Intervention Results of a Randomized Controlled Trial. *Arch Intern Med.* 2006; 166(17):1822-1828. doi:10.1001/archinte.166.17.1822

SWAN hospitals[10]. The daily digests are then used by health systems to coordinate care for members. The SWAN digest allows health systems to connect with members they otherwise may not have known needed assistance to provide medication reconciliation, a primary care follow-up after an inpatient stay, and general follow-up to ensure care plans are being followed.

When health systems increase coordination during transitions of care, evidence shows a reduction in preventable readmissions. Health systems in an APM model with Medicaid and Wellmark are being measured on their ability to reduce preventable readmissions and ED visits and conduct a follow-up after hospitalization within 30 days through the VIS measure set. These quality measures are tied to payment in Iowa. The SWAN system is enabling providers to be more successful.

Current Reality:

Iowa is currently receiving eligibility files for 2 of the 5 Medicaid ACO's and 1 of the 3 MCO's. We have 28 out of 118 hospitals sending ADT's to SWAN. The alert files are being sent to the receiving ACO/MCO on a daily basis in an SFTP file. Both Broadlawns (ACO) and Iowa Health+ (ACO) have these daily digest alert file automatically downloaded to their EHR workflow so that they can act on the alert accordingly and provide the appropriate follow up.

SWAN Success Stories:

- ✓ A member had a snowmobile accident that happened in Northern Iowa. The use of the SWAN enabled the primary care provider to follow up with the member. Specifically, the patient verbalized they were impressed that the Care team knew of the event and were thankful for the connection.

- ✓ A patient with congestive heart failure, a history of MI, HTN, A-Fib, Stage 3 CKD, PE, on long term anti-coagula, pulmonary hypertension and metastatic cancer had been in and out of several area hospitals. His primary care provider was alerted by SWAN of his admissions at which point staff/providers were able to fax his records to the admitting hospital, including information regarding the member's 3 month history of Coumadin therapy management. This was crucial for management of what turned out to be a critical cardiac issue. Before the patient was discharged from the hospital, his primary care provider was able to review his admission records, enabling a referral to home health for coagulation management and a follow-up appointment was scheduled with his primary care provider. Additional collaboration for discharge planning, including hospice care and medical management of his chronic diseases was also completed. This example truly shows the impact that SWAN can have on patient care by ensuring clear communication and closed referral loops.

[10] As of January 2017, 27 Iowa hospitals are SWAN participants. At least one hospital from each of the Medicaid ACOs participates in SWAN.

AY3 Activities:

During Award Year 3 Iowa is focusing efforts to improve SWAN by increasing the number of hospitals sending ADTs to SWAN, improve the use of the daily digest by participating health systems and increase the populations included in the alerts. Those activities include

- Promote use of SWAN and the other services of the IHIN among providers
- Connect 45 hospitals to send ADT files to SWAN
- Pilot the expansion of alerts to Medicare population
- Expand alerts to non-ACO provider types
- Develop a fact sheet on value of sending ADTs and use of SWAN alerts
- Conduct 5 user group meetings
- Provide Technical assistance to use SWAN alerts to improve outcomes

More detail on the plan to accomplish this improvement can be found in the Health IT Improvement plan, Appendix D. See Section C for detailed milestones, action steps, and dates of the activities related to **how** Iowa will utilize and expand SWAN as part of the delivery system model.

2. Statewide Strategy Plans

The Statewide Strategy Plans are consensus and guidance documents that outline unifying goals and actions to be taken to address an identified priority heath issue, promote alignment of resources and efforts, and advance the health and wellness of all Iowans. The state plans are developed through a cross-sector, collaborative process, convening key partners and stakeholders from across the healthcare continuum. The group is inclusive of state and local agencies, professional associations, independent providers, payers, health systems, and consumers and patient representatives. The plans are designed to establish a statewide standard of care, complement one another, and support statewide and local community action to achieve community-applied, population-based health.

How it Works:

These plans offer a “roadmap” of specific opportunities that stakeholders and partners from throughout the health continuum can undertake to improve their practice, delivery of services, engagement and experiences of care, community wellness, and overall population health. The plans are intended to be guidance documents offering a menu of options that support statewide application and local community application.

Each plan is supported by a statewide task force consisting of individuals who took part in the development of the plans. They continue to meet for ongoing review of the plans and report progress, ensuring that the statewide strategies remain meaningful and actionable. Roles and responsibilities of the work group members are laid out in the development phase with expectations that participants will utilize the plans to support their collective initiatives and activities. Work groups are convened twice a year at a minimum, to share updates and work completed to support the tactical goals of the plans. This process not only supports top-level execution of the statewide strategies, but also seeks to ensure that resource provisions and

communication to local partners and communities is consistent and aligned among stakeholders.

Impact on and utilization by local communities was a vital consideration in the development of the statewide strategies, seeking to ensure that the strategic plans go beyond a state-level view to include support for community-led approaches. The documents are organized by overarching goals, supporting objectives, and tactical actions that communities can use as a template to establish their local actions to address each key issue. The plans also illuminate and call attention to collaboration across disciplines and settings. This sets the stage for identifying key local partners to engage and invite to the table. These strategies are of particular value to the SIM C3 pilot communities as they are to be utilized to develop their work plans to address the priorities defined in their scope of work and improve overall health in their communities.

Current Reality:

There are currently eleven Statewide Strategy Plans in place: Care Coordination, Cardiovascular and Stroke, Diabetes, Healthcare-Associated Infections, Palliative Care (Iowa Physicians' Orders for Scope of Treatment), Medication Safety & Effectiveness, Obstetrical Care, Obesity, Person and Family Engagement (PFE), Tobacco Prevention and Reduction, and Social Determinants of Health (SDH) (currently in the finalization process). Five of these plans, were developed in 2016 in support of the key priority areas identified within the Iowa SIM project. The statewide strategic plans are aligned documents that establish statewide expectations for health and healthcare, without ownership to any one initiative, program, or agenda. They seek to align resources and actions that drive coordinated execution towards the common goal. Over 30 organizations convened several times to develop, review, and integrate the plans throughout the state.

AY3 Activities:

In AY 3, the Iowa Healthcare Collaborative (IHC) will continue execution of the statewide strategic plans, in coordination with the Iowa Department of Public Health.

- Develop a new plan aimed at health systems to laying out detailed functions and opportunities that drive Iowa health care systems towards person-centered, population-focused, value-based care. This plan will build upon the momentum and foundation offered by the existing statewide strategies, honing in on the specific roles and responsibilities of the more traditional health care system to begin to shift practice to a focus on whole-system community presence and engagement.
- Seek to increase meaningful utilization of the statewide strategies, with particular emphasis on key cross-cutting, priority strategies for diabetes, care coordination, medication safety and effectiveness, person and family engagement, and social determinants of health.
- C3s will implement required tactics from the statewide strategy plans to improve health outcomes for individuals having diabetes or at risk for developing diabetes. See Attachment II of Appendix E for additional detail on the tactics being implemented in C3 regions.

- Provide tactics from the statewide strategy plans to non-C3 counties that have identified diabetes in local health improvement plans.
- Promote the statewide strategy plans through a variety of venues including but not limited to websites, newsletters, and conference presentations

See Section C for detailed milestones, action steps and dates of the activities related to **how** Iowa will utilize the Statewide Strategy Plans to advance the Population Health Roadmap implementation to improve care coordination in Iowa's delivery.

3. Community Scorecard:

A community scorecard is a tool created to provide community-level data that can be used to align communities and health systems to thrive in a population-based reimbursement model. Community scorecards contain valuable state and local data for comparison and benchmarking, leading the way for building local capacity for healthcare transformation and community-based quality improvement. In Iowa, the scorecards will be a valuable and trusted resource to strengthen partnerships and give direction for improved health. Community scorecards will be developed for: 1) existing C3 pilots and, 2) healthcare systems receiving SIM Technical Assistance outside of the C3 areas. The Iowa Healthcare Collaborative (IHC) working with key SIM partners will manage and facilitate the community scorecards.

How it Works:

Currently, the IHC administers the SIM Portal database. A figure found in Appendix D of the HIT Enhancement Planning document illustrates how the community data are collected and analyzed in the SIM portal to create a scorecard. The SIM portal acts as a data repository for the six Community Clinical Care (C3) pilots and identified healthcare systems. The data from the SIM Portal used for the C3 scorecards includes social determinate of health referral data and C3 process improvement measures and the following clinical measures:

- Hemoglobin A1c Management
- ED, Readmissions, TCOC (specific to diabetes population)
- Diabetes co-morbidities (Obesity and Tobacco Use)
- Completion of Diabetes prevention education
- Diabetes prevalence

Unique scorecards will be made available quarterly to C3 ~~providers~~ and health systems engaged in SIM Healthcare technical assistance. IHC Quality Improvement Advisors, working with C3 steering committees, will facilitate scorecard review and process improvement activities for selected community health topics. Topics will include implementing tactics from each C3 work plan that will drive improvement in the scorecard results for the next quarter.

Examples of improvement activities and topics include:

- Build skills to interpret the community scorecard and tactics for how best to share results with partners
- Prioritize work efforts to drive process improvement (example: determine if additional community service partners are needed)

The healthcare systems outside of the C3 areas, will utilize community scorecards to advance a care model to emulate Accountable Communities of Health that advance improvement in value-based care models. In those areas, hospitals, rather than C3s, will be encouraged and supported to act as the local convener. The scorecard will be one of the strategic tools used to help align health delivery systems to enhance community engagement that ultimately improves their ability to manage their population.

To the scorecard for the non-C3 areas, will require development of additional measures. IHC will partner with key state organizations and health systems to identify and utilize available hospital clinical data, federal data, appropriate public/local data and non-public data. Community scorecards will align with hospitals, clinics and communities. Currently, several hospitals use their internal data to drive quality and process improvement for care coordination. IHC will deliver education and technical assistance to help optimize utilization of the community scorecard, supporting execution of community-wide health transformation.

Examples of Education and Technical Assistant activities include:

- Education to introduce to the concept, value and utilization of community scorecards.
- Support hospital activities to introduce and integrate the scorecards within community groups
- To support duplication, identify community scorecard successful efforts and share information on the SIMplify communication platform

Technical assistance related to health systems transformation will differ in areas beyond the Community and Care Coordination projects in that the health systems rather than C3s will be the target audience for TA activities. However, provider engagement strategies will be uniform across Iowa. Communications about health systems transformation and community population health involvement are better accepted when delivered by trusted sources.

- Planned engagement activities for regions without a C3 include: In-person MACRA, VBP, APMs training from recognized educators, physicians and consultants also;
- Readily accessible electronic QPP information and understanding the value and use of the SWAN, HRAs, and IHIN,
- Access to data analytics and reports reflecting the health and needs of communities (e.g., Community Score cards)
- Uniform communications from ACO level leadership about participation in SIM and DHS health systems transformation
- Information about and direction on how to participate in community services referral processes (e.g., social determinants referrals)
- Health systems transformation communications and resources from Iowa health/medical professional associations

The community scorecards is a tool that allows our SIM TA sub-contractor to help C3s and healthcare systems identify and prioritize community health and high cost issues; Track inputs and investment; Monitor quality of services/projects; Generate benchmark performance criteria that can be used in resource allocation and budget decision; Compare performance across facilities/districts: and use as a Mechanisms of direct feedback between providers and users.

Current Reality:

Iowa did not roll out community scorecards during AY2. However, SIM partner organizations (e.g., health systems, local health departments) currently collect much of data that will be included in the scorecards. During AY2, data use agreements where put in place, protections for secure transfer of data, and data workflow plans that support development of scorecards were developed. IHC SIM Data staff identified data from the existing SIM Portal and potential HIIN data from non-C3 hospitals to begin the project, and will work closely with IDPH and other organizations to prioritize and obtain access to additional data for the scorecards.

The state anticipates a positive reception of to use community scorecards for the following reasons:

- This is a tool previously used in Iowa, our communities and hospitals already work together prioritizing data and health issues from community health needs assessments,
- Public health, health care systems, and community services organizations currently use state, local and national data and;
- Health care providers and other health professionals respect and value data driven initiatives and understand data as a sustaining factor.

AY3 Activities:

- Expand the SIM Data Portal capacity to support C3s and health systems outside of C3s
- IHC will lead the effort to collect, analyze and report data for the scorecards
- Because this group does not have SIM portal data, IHC will convene stakeholder groups to analyze, discuss, and make decisions on non C3 scorecard metrics.
- Provide community scorecards quarterly to C3s and Health Systems outside of C3s
- Complete process improvement (PDSA) cycles to sustain community-wide health transformation

4. Implementation of a Standard Health Risk Assessment Tool(s)

The Iowa Health and Wellness Plan (IHAWP) legislation, Senate File 446, became effective January 1, 2014. It required the Iowa Medicaid Enterprise (IME) to take approaches to increase access to health care, improve quality health outcomes, incentivize personal responsibility, endorse cost-conscious utilization of care, and adopt preventive and healthy behaviors. In addition, the legislation required IME to develop a strategy to address population health and health promotion.

The Healthy Behaviors program was implemented within the IHAWP program. Members were required to complete an annual wellness exam as well as a health screening tool in order to be exempt from the required premium payment in the next year of enrollment. Providers were incentivized for assisting their patients to complete both behaviors. This included a $25 per member payment upon receipt of a clean claim for a completed HRA that was incorporated into the Plan of Care. Further reimbursement was in the form of a $4 per member per month payment at-risk if the ACO did not met their targets for percent of patients completing both Healthy Behaviors. These incentives were sunset on December 31, 2015 in preparation for Managed Care Organizations to begin serving the population.

This inspired investment in a health risk assessment (HRA) tool to identify and influence social determinants of health, recognizing their personal and collective impact on the health of Iowa's communities. Leaders desired a tool that would assist members to think about their health while taking the assessment and creating personalized health action plans to discuss with their provider. It was important to enable providers to review these plans with their patients and review aggregated data as a snapshot of demographics and illness burden within the practice. The provision of information to multiple stakeholders that was immediately actionable and triggered specific interventions to support health outcomes was necessary to transform clinical interventions and connect them with supportive community services. The AssessMyHealth tool was chosen for these reasons.

In 2015, 3M and Treo Solutions[11] reported the preliminary results of the use of AssessMyHealth with the Iowa Health and Wellness population. They specifically reported several outcomes related to the Health Confidence measure. When analyzing the "Percent of patients reporting confidence sorted by illness burden categories", the results revealed four categories of patients that indicated higher percentages of "Confident" vs. "Not confident" responses. Patients who were categorized as "Catastrophic", "Significant acute", "Healthy non-user", or "Healthy" fit this description. The other seven categories of patients responded "Not confident". This information leads to a conclusion that significant engagement with a provider and perceived health lead to health confidence. The implications of indicating "Somewhat confident/not very confident" were shown to be increased ER use for chronic disease, more than one hospital or ER use (perhaps unnecessary), time lost from work, and thinking medications were causing illness. Finally, the vendors represented how "Confidence has cost implications." Those who were "Very confident" had a lower total cost (35% lower) PMPM than patients reporting they were "Somewhat confident/ not very confident." Confident patients also incurred lower prescription costs.

The purposes of 3M's AssessMyHealth tool are:

- Foster better communication between patient and provider, which can lead to improved health outcomes
- Identify patient needs as they relate to the multiple determinants of health outcomes
- Provide patients with access to education and resources for managing their own care

[11] 3M & Treo Solutions. (2015). Patient *reported data: AssessMyHealth early results for Iowa Medicaid.* [PowerPoint Slides]. 3M Health Information Systems. Slides 11-13.

This tool lends itself to addressing health literacy through the inclusion of basic drawings to assist in selecting answers. It contains an appropriate range of question topics including social determinant questions, and provides the patient the opportunity to answer follow-up questions to provide more details where they are needed. It also includes a question that is somewhat unique among risk assessments. Question number 5 is, "Choose Your Health Confidence Number." The answers include a scale of 0 (very low) to 10 (very high) along with a picture that includes facial expressions as well as colors ranging from green to yellow to orange and then red. The question can also be answered with a choice of phrases.

In support of using a measure of health confidence to transform the delivery and payment systems, Mark M. Nunlist, et al (2016) published a white paper on the topic.[12] A key point the authors make is, "Health confidence reporting and measurement can provide a wealth of benefits to the practice and the patient. Collecting the patient's health confidence rating as a vital sign is simple, inexpensive, and provides information that is immediately actionable. Improved health confidence correlates with improved patient health and reduced use of hospital services – strong arguments for employing this measure as a foundational metric of health care delivery and provider reimbursement." (Nunlist et al, 2016). Patients who indicate low health confidence in connection with poor chronic condition control, high ER utilization, or poor adherence to appointments, among other factors can be identified and flagged for focused care coordination from the provider (i.e. motivational interviewing practices). Intensive interventions for these patients have been found to increase the patient's health confidence. Positive outcomes could be expected to follow such an increase, building support for this process of assessment and intervention. In general, supporting providers to analyze and act on the individual and aggregated data collected from a health risk assessment that includes this measure will link to the provision of higher quality care and actively link payment to performance (VBP).

The state will also identify additional social needs questions to be added to the tool based on the six social determinants of health focus areas of health and health care access, food insecurity, supportive housing, education and literacy, social support, and transportation. Risks identified as potential causes of poor health outcomes can then be addressed through referrals to C3s. This data can be tracked and reported through that pilot and evaluated.

The proposed questions are:

- In the last 12 months how often would you say that the food you bought just didn't last and you didn't have enough money to get more.
- How difficult is it for you to understand information that doctors, nurses and other health professionals tell you?
- In the past 12 months, was there any time when you needed care for an illness, injury, or other condition but could not get it for any reason?

[12] Nunlist, M.M., Blumberg, J., Uiterwyk, S., & Apgar, T. (2016, November/December). *Using health confidence to improve patient outcomes.* Family Practice Management. 21-24.

- Thinking of the most recent time you could not get to a healthcare visit because you did not have a ride, what was MAIN reason you could not get there? OR When you need to get healthcare, how do you MOST OFTEN get to your visit?
- During the past 4 weeks, was someone available to help you if you needed and wanted help?
- Do you have enough money to buy the things you need every day (food, clothing, and housing)? (This question is already included in AssessMyHealth.)

To pilot expanded use of a common HRA during AY3, Medicaid is considering contract levers with financial consequences for each of the three MCO's to incentivize them to support their member population to complete an annual HRA using AssessMyHealth (AMH) OR at least use a common subset of state selected social need questions. In order to achieve this they, in turn, will modify their contracts with providers to ensure their attention and cooperation to this important activity. Use of AMH will be highly suggested, but not required. The team will add social needs questions to this tool as previously discussed. If the MCO chooses not to utilize the AMH tool, they will be required to add these questions verbatim to their current tools and to ensure that the data can be aggregated and shared. 3M will provide the technical and data support for the AMH tool and will produce reports based on the leadership team's guidance.

Aggregated data will be shared with physician clinics, hospital partners, C3 agencies, state and local public health agencies, SIM Leadership Team members and their organizations, SIM evaluation partners and other entities as they are identified. This data will lend itself to discussions that will lead to developing new strategies for delivery system reform as well as the importance of linking the completion of an HRA and use of its results to Value Based Purchasing arrangements. The Health Confidence question, with its link to identifying patient activation and potential for successful health management, has the most potential for instituting delivery system changes and payment incentives for performance improvement. The delivery system is transformed through adoption and implementation of an HRA and Health Confidence measurement, analysis of this data, and associated follow-up interventions. The payment system is transformed through payment incentives dependent upon performance related to their population's Health Confidence Score and outcomes for at-risk patients.

The leadership team will also explore opportunities to extend the adoption of a statewide HRA to the general population. Conversations are occurring with other payers and statewide organizations such as Wellmark and Iowa's Healthiest State Initiative. As previously discussed, the team will suggest AssessMyHealth as the tool to be used across sectors with the justification being the collection and reporting of the data with special attention to Question 5 and to the social needs questions. 3M has the capacity to support the increased number of assessments, making just a few modifications in identifiers.

How it Works:

AssessMyHealth is a secure, web-based health risk assessment that is simple to use. It can be completed over the phone, in-person, and online using paper or electronic means. Reports can be printed by the patient immediately upon completion and a notification is sent to the primary care physician who can then also view the results. The patient is directed by the tool to print the

document and bring it with them to their next physician appointment. The physician is asked to review the results with the patient, provide guidance related to their needs, and make appropriate referrals before signing the document. The document is to be stored in the patient record after it is incorporated into the patient's care plan. 3M has the ability to aggregate the data in a number of ways and produce reports regularly.

Current Reality:

There are several health care provider, payer, and community-based organizations across Iowa who are using a health risk assessment tool. These tools vary as to what questions are asked, how they are asked, and how the tool is utilized within their structure to improve care. Because there are organizational work flows and financial investments connected to these tools, the state's suggestion to utilize a common tool is being met with some resistance.

There is, however, support and energy surrounding the request to collect a standardized set of social needs questions and aggregation of that data to be shared with entities for program planning and quality improvement. Agencies are not completely opposed to including additional questions to their tools, although it will take some time to operationalize these changes and grow a system for aggregation of the data collected by each organization.

There are specific opportunities surrounding the use of the Health Confidence question. It may be possible to explore and pilot the addition of this question within existing organizational HRA tools. Technical assistance to the health care system could be utilized to advocate for the inclusion of the self-reported health confidence question and associated follow-up into clinic work flows. The AHRQ has published, *"Health Assessments in Primary care: A How-to Guide for Clinicians and Staff"* which includes chapters on work flow incorporation, using health assessment data, and sustaining this practice. The information can be found here. Further, Managed Care Organizations could insert the Health Confidence question into their existing HRA tools. Aggregating and analyzing the responses would inform quality improvement strategies and patient engagement. Both activities would impact population health outcomes as this practice could easily be spread across the health care community with a goal of normalizing the measure of health confidence as an indicator of patient outcomes and identification of this measure as a trigger for further assessment of social needs.

AY3 Activities:

- Deploy AMH as NCQA Certified Health Risk Screening Tool
- Identify SDH questions for approval by Leadership team, stakeholders, and partners and add them to the tool or recommend their use within other tools.
- Discuss use of AMH with Wellmark and with the Healthiest State Initiative to begin utilization of a HRA by the general population.

See Section C for detailed milestones, action steps and dates of the activities related to **how** Iowa will utilize the collection of SDH data as part of payment reform and delivery system transformation funded through SIM.

5. **Community & Clinical Care (C3) Initiative:**

Community and Clinical Care (C3) Initiatives are multi-sector groups of stakeholders that include both traditional (clinical-based healthcare) providers and other community based providers and public health organizations implementing innovative strategies and referral processes to meet the clinical and social needs of a defined population. The C3 pilot in Iowa is testing whether specified clinical tactics, enhanced referral systems to community-based resources and subject-matter technical assistance lead to better quality outcomes for healthcare providers in the C3 regions, and ultimately improved health outcomes and quality of life for patients. The pilot also addresses provider engagement in community care coordination. As an outcome, C3-associated healthcare partners will identify how clinical interventions, when aligned at the community level, influence the outcomes of their quality measures tied to payment. This will prepare the group for increased risk contracting (VBP) in Iowa.

This is accomplished through person-centered, coordinated care across a range of providers. Iowa's C3s have two primary functions: 1) addressing social determinants of health through care coordination; and 2) implementing population-based, community-applied interventions related to the Iowa SIM Statewide Strategies. In AY2, Statewide Strategy Plans were created through cross-sector planning sessions. There are currently seven plans and they can be found here: http://idph.iowa.gov/sim. In AY3, full implementation of the relevant Statewide Strategy Plans will occur.

These initiatives are intended to 1) enhance care coordination and transitions for both providers and patients by identifying population risks and addressing barriers to health such as social determinants of health by connecting patients (and providers) to community resources, and 2) develop and implement locally-identified tactics from the statewide strategies to address a specified health condition. The Iowa SIM project will focus C3 efforts on addressing diabetes and risk factors related to this disease in Award Years 3 and 4. For more information on this focus please see the Roadmap to Improve Population Health in Appendix E.

How it Works:

For AY3, the C3 Initiative is structured using the Accountable Communities for Health (ACH) framework. The required C3 governance structure consists of 1) an applicant that provides administrative and fiscal oversight of the project; 2) an integrator organization that may also serve as the applicant organization and acts as a neutral partner outside of the clinical healthcare delivery system, convening partners and facilitating community-based grant activities; 3) a small steering committee with required membership of local public health, at least one ACO (if applicable), a local healthcare provider representative, at least one hospital, and the integrator organization; 4) a multi-sector coalition that serves as a source of communication and collaboration to drive implementation of the project; and 5) required staffing (paid or in-kind) to include a C3 project director, community-based care coordinator, and data coordinator.

A patient's social needs are addressed through a local care coordination referral system. Three of the six C3s have existing health IT systems in place to support community care coordination. The other three have or are creating referral systems and are researching care coordination IT

systems. Examples of how a C3 referral process may be implanted can be found in Appendix D, Health IT Plan, pages 12 and 13.

The C3s ensure that population-based prevention and treatment activities are implemented in alignment with required tactics from Iowa's Statewide Strategy Plans. The target populations for the C3s are individuals having diabetes and those at risk for having diabetes. The C3 regions also seek to reduce preventable inpatient readmissions and preventable emergency department visits.
The C3s will implement required tactics related to the following seven objectives:

- Identify target population by risk,
- Improve diabetes management,
- Link to community resources and clinical-community programs,
- Improve healthcare transitions,
- Decrease the incidence of diabetes,
- Address community-wide prevention, and
- Develop and maintain the C3 structure

Clinical quality measures are tracked and technical assistance around process improvement is provided as described below under "Health Care Technical Assistance."

Current Reality:
Community and Clinical Care (C3) Initiatives are multi-sector groups of stakeholders that include both traditional (clinical-based healthcare) providers, other community based providers and public health organizations implementing innovative strategies and referral processes to meet the clinical and social needs of a defined population. In Award Year 3, Iowa will maintain the same number of initiatives as in the previous Award Year. There will be no expansion of awards or regions. This will allow for a more focused effort and quality implementation of SIM activities and should be considered a proof-of-concept pilot that an organized health system integrated into a community will impact both quality outcomes and cost.

The C3 pilot will test whether specified clinical tactics, enhanced referral systems to community-based resources, and subject-matter technical assistance will lead to better quality outcomes for healthcare providers in the C3 regions, and ultimately improved health outcomes and quality of life for patients. This pilot will also address provider engagement in community care coordination. As an outcome, C3-associated healthcare partners will identify how clinical interventions, when aligned at the community level, influence the outcomes of their quality measures tied to payment. This will prepare the group for increased risk contracting (VBP) in Iowa.

In AY2, six C3 regions covering 19 counties were awarded funding to execute two primary functions: 1) addressing social determinants of health through care coordination; and 2) implementing population-based, community-applied interventions. The C3s have spent AY2 building capacity for referrals for social needs, partnerships, and clinical-community linkages. Two documents highlighting the C3 successes in AY2 may be found in Appendix H.

AY3 Activities:

The Iowa SIM project will focus C3 efforts on addressing diabetes and risk factors related to this disease in Award Years 3 and 4

For AY3, the scope of work for the C3s will provide greater alignment with other areas of the SIM and include required:

- Connection to the Iowa Health Information Network to support closed loop referral process;
- Participation in the SWAN;
- Work plan activities that are primarily focused on the traditional clinical and innovative clinical buckets of the CDC's "3 Buckets of Prevention;"
- Core set of clinical quality measures that all C3s collect and report;
- Resource sharing between hospitals/clinics and local public health or other community-based provider(s); and
- Upside and downside risk in the form of contract performance measures related to improvement in clinical quality measures and increased participation in the National Diabetes Prevention Program and Diabetes Self-Management Program.

See Section C for detailed milestones, action steps and dates of the activities related to **how** Iowa will utilize C3s within Delivery System Transformation. For more information on C3s please see the Roadmap to Improve Population Health in Appendix E.

6. SIM Technical Assistance:

Technical assistance (TA) is one of the SIM program strategies designed to expand community level execution to improve care and healthcare collaboration across stakeholder groups. SIM TA will guide local changes needed to address healthcare quality and improve access to accountable and affordable healthcare for Iowans. The Iowa Healthcare Collaborative (IHC) will lead SIM TA activities. IHC plays a unique role in putting healthcare providers in a leadership position to drive clinical improvements that impact their local environment and accelerate statewide change.

IHC has insight into health systems, provider/physician and clinic management technical assistance needs that help guide their strategies. Health care systems are requesting training on the use of data, metrics, and analytics to guide change, compliance, and service area strategies. Physicians are interested in receiving more information about QPP and how it will affect them. Clinical managers are seeking quality improvement and process improvement training and patient safety information.

IHC employs a cadre of professionals who are all Masters, Ph.D., or Physician-level prepared. They have experiential expertise in; medical care, quality improvement, healthcare administration, public health, data analytics, and adult education/training and development. The organization uses a cross-sector approach to bring together and engage providers, hospitals, insurers, employers, consumers and community partners to share data and rapidly deploy best practices.

In the first two years of SIM, IHC operated as a subcontractor to provide a broad array of technical assistance for the Community & Clinical Care (C3) pilot communities. The IHC will begin a second scope of work that focuses on engagement of Iowa's large provider healthcare systems participating in Value-based Purchasing agreements, supporting their transformation efforts with special attention to metrics, analytics, process improvement, and provider engagement. Technical assistance will be focused on promoting skills for providers to increase successful outcomes in value-based payment systems using the Value Index Score, SWAN, and Health Risk Assessments.

How it Works:

Community & Clinical Care (C3s) Pilot Technical Assistance

In AY2, the C3s built on strategies to optimize local community alignment, infrastructure and function moving toward transformation. TA education/training activities included site visits, webinars, virtual training, regional workshops and statewide conferences. These were led by SIM staff, IHC Education staff, QI Advisors and IHC faculty with specialized training, credentials, and certifications.

In the C3s, use of the Accountable Communities for Health structure guided proficiency in standard language, and cross-sector initiated commitment to quality and change. Work to date has focused on convening, expediting commitment, execution of C3 Quality Improvement plans, and data submission. In AY2 a SIM Portal was constructed and revised to accommodate the type data that local C3s need for process improvement and the IA SIM need for reporting purposes. To date portal data are:

- Social Determinant of Health referral data (collected by C3s)
- QuitLine client referrals (collected by C3s)
- County-level Medicaid potentially preventable patient ER visits (administrative claims data)
- Four NQF measures (collected by clinics)
    - Tobacco Use: Screening and Cessation Intervention: NQF #0028
    - BMI Screening and Follow-up: NQF #0421
    - Hemoglobin A1c Management: NQF #0059
    - Weight Assessment and Counseling in Children: NQF #0024
- Two HIIN measures (collected by hospitals)
    - Healthcare Acquired Infections
    - Adverse Drug Events
- C3 QI process measures (collected by C3s)

The C3s have access to the data and reports are available monthly. The C3 quality improvement process measures were identified by the C3 and reflect their IDPH work plans and are submitted monthly and through the performance improvement process, allow the C3 to determine their QI results and identify work patterns to increase value. The QI metrics and process measures for the metrics are:

- Provider participation - Process metric - Number of attendees (steering committee) / Total number of individuals on steering committee
- Care coordination inquiry - Process metric - Number of Referrals by type (provider, community partner, self) / Total number of referrals
- Social Determinants of health - Process metric - Number of rides given by type (vouchers, Sail-DC) / Total number of rides given
- Diabetes - Process metric - Total number of NDPP self-referrals / Total number of NDPP referrals

Health Care Systems Technical Assistance

Education and technical assistance (TA) will help prepare health systems and communities for rapidly expanding health payment reform and delivery system expectations. Qualified entities will promote collaboration and transparency to align and coordinate technical assistance activities. Contracts will be established with each of Iowa's three major Accountable Care Organizations (Unity Point Partners, Mercy ACO, and University of Iowa Health Alliance). Three ACO liaisons from the SIM Technical Assistance Vendor will be embedded into the contracted ACOs to promote SIM goals, assist with IHC TA activities, promote communication transparency and provide valuable input.

Provider Engagement is a key factor in the success of health systems transformation. Providers have a significant role in community health and promoting a referral process enabling patients to access community services for improved outcomes. A four-pronged provider engagement TA approach equips providers for success:

1) Providing unique education, data, and communication resources.
    a. VIS strategies for quality and cost improvements
    b. SWAN utilized to improve care coordination for transitions of care
    c. Health Risk Assessments for patient engagement and social determinant needs
    d. Utilizing Community Scorecards for process improvement needs
    e. SIMplify communication portal as a unique site to disseminate Provider resources and share information
2) Utilizing collaborative partnerships with provider associations and professional groups as rallying forces. The Iowa Medical Society, Pharmacy Association, Primary Care Association and Hospital Association each have the capacity to influence their many professional members towards collaborative and partner relations with SIM. Through their educational, communications efforts and knowledge of health systems transformation; associations and professional groups can assist SIM with AY3 efforts.
3) Identifying physician and provider champions who have credibility and can speak personally to providers. Engaging a recognized and respected individual to serve as a "champion" to increase trust, understanding, and involvement is a proven strategy. Health providers as other professionals are more likely to listen to a message, have open discussion and

4) Find answers on issues that affect their profession when exchanging thoughts and information with another provider. The SIM TA Vendor utilizing IHC faculty physicians will continue doing requested presentations and small group discussions with hospitals and clinics on MACRA, community health and other relevant health topics,
5) Appealing to and supporting professional missions and challenges towards integrated population health and value-based care into a sustainable organized local healthcare delivery system, including the complexities of rapidly changing health care landscape and how physicians and providers can be involved as change agents and leaders.

To promote provider engagement and support the IA SIM program, the IHC secured contractual agreements with the Iowa Medical Society (IMS), the Iowa Pharmacy Association (IPA), and the Iowa Primary Care Association (IA PCA). The contract agreements prompt these partners to, "*Provide communication, education, situational awareness, and profession-wide sense-making concerning SIM activities among membership"*. The IA PCA will also deliver social determinants of health education, training, and resources to C3 communities and providers. Since October 2016, approximately 700 IPA, IMS, IA PCA provider members were reached through the provision of information via websites, newsletters, educational presentations and videos.

Beginning in October 2016, IHC President/CEO, Dr. Tom Evans, M.D., initiated a *Health System Transformation* presentation series supporting community integration & QPP. These presentations are directed toward hospital administrators and providers. During Award Year 3, the presentations will be delivered at each of the seven Iowa Hospital Association (IHA) regions, covering 118 Iowa hospitals. Dr. Don Klitgaard, M.D, is faculty advisor at IHC. Within the SIM, he serves as the lead for provider engagement. He is also the president of the Heartland Rural Physicians Alliance and is on the Board of Directors of the Iowa Academy of Family Physicians. Dr. Klitgaard can provide guidance to his peers related to VBP, QPP, and community health integration.

Current Reality:

Beginning in March of AY 2, IHC provided each C3 and many health providers with technical assistance including an array of resources and tools, education and training opportunities, Improvement Advisors, access to in-house faculty consultants, and a dedicated C3 communication and networking portal. To involve communities, partners and providers statewide, four SIM Learning Community events were convened which featured national speakers and statewide efforts. Topics during Past Learning Community events agenda presentations included; Sioux C3 Project "Care Coordination in a Rural Environment", "What to Expect from Managed Care", Medication Management in the Community", Social Determinants of Health "The Non-Medical Drivers of Health" and MACRA- "What You Need to Know".

Additionally, to document, improve and sustain process improvement, the IHC developed a data collection system to produce a community scorecard. This scorecard as a tool in delivery system reform is described above.

TA deliverables include:

Education-training-site visits

- Four Statewide SIM Learning Community conferences with over 1,000 attendees; Three C3 Regional Workshops; Ten on-site presentations by IHC faculty; Four training webinars and Two webcasts.
- Thirty-eight C3 TA site visits by IHC staff. Visits included C3 Quality Improvement Work Plan, PDSA cycle training, data analysis training and skills building, clinical partner referral improvement, VBP, MIP/MACRA and Quality Performance Payment (QPP) basic information.
- The Alliance for Integrated Medication Management (AIMM) completed medication assessment discussions with the C3s, and interviews with key C3 partners. AIMM send each C3 a memo detailing information from the interviews. The intent of AIMM efforts were to: Develop tailored strategies to assist the Community Care Coalitions (C3s) to address integrated, community medication therapy management, focusing on care for persons living with diabetes and targeted patient safety needs of each community. In January, two of the C3s requested AIMM return to their communities to participate in community wide medication management planning.
- Social determinants of health (SDH) TA including: C3 assessment interviews, SDH Information Briefs, 2 webinars, and a SDH panel presentation at the SIM Learning Community. The SDH resources, webcasts, videos and SDH resources have been posted on the C3 SIMplify communication platform to increase dissemination. Additionally, C3 SDH TA site visits were completed for five of the six C3. Site visit TA activities resulted in:

    - A community meeting to identify partners and community service providers;
    - A two-day community forum to engage partners and identify SDH needs and high risk populations;
    - Focus group meeting with 3 agencies that utilize the C3 organization and SDH services;
    - A SDH mapping training to help C3 staff identify SDH high need populations;
    - A C3 meeting to increase SDH understanding for local health department staff;
        - Each of the SDH TA site visits included an evaluation and the C3 received a report.

Communication

- Monthly C3 “connect” conference calls with each of the 6 C3s. The calls provide information exchange between IHC and C3 staff
- SIMplify, online communication platform for the C3s continues to grow. In late August, 2-week Topic Cycles were introduced to stimulate information flow. The cycle topics were: care coordination, provider engagement, diabetes, statewide strategies, patient centered medical home, MACRA, and population health. SIMplify communication portal stats are:

    - Website Pages Viewed: 13,522
    - Discussion Posts Written: 1502
    - Library Entries Viewed: 1382
    - Library Entries Posted: 888

- Discussion Group Subscriptions: 540
- Contact Invitations Sent: 255
- Contacts (Friends): 176
- Community Membership: 152
- SIMplify Newsletter is disseminated monthly, there are 460 subscribers.

Data

- The IHC-SIM Data Portal was rebuilt and includes: HIIN data measures from hospitals, NQF measures from clinics in C3 counties, C3 data for Quitline and social determinants of health client referrals, C3 QI process measures, and Medicaid Potentially Preventable Admissions data for each of the C3 counties (19). Each C3 received orientation to the portal, and a training webcast was completed and is available online.
- GIS mapping services are available to the C3s to enhance planning and delivery of client services. The first maps code Medicaid admits by zip code to C3 organizations. Training videos were released in November.

AY3 Activities:

In AY3 and AY4, IHC will continue work with the C3s, but with a more centralized approach to advance these communities with continued implementation of the Accountable Communities for Health (ACH) strategies and engage them in their important role in health care transformation. These pilot communities will be assisted to demonstrate best practices that support alignment and sustainable transformation. To engage providers in population health, C3 technical assistance will adopt from the CMMI Transforming Clinical Practice in IA (TCPI) program framework (e.g., best practice strategies), to execute community-based performance improvement and these best practices will be shared with the non-C3 providers to diffuse the innovations.

C3 Technical Assistance:

Components for partners participating in C3 arrangements

- Assign performance improvement coaches (QI) to each community to inform and advance process improvements
- Continued emphasis on activities to improve health and decrease rates of preventable hospitalization and readmissions including: medication safety and management, person and family engagement, and health literacy
- Utilize a community scorecard to inform process improvement
- Promote resource sharing between providers/clinicians and C3s
- Provide help desk infrastructure, data analytics, and reporting for SIM leadership, C3s, and clinic partners.
- Promote applications of the IDPH Population Health Roadmap strategies for population health management in rural environments.
- Facilitate C3s in community-wide implementation of tactics within the statewide strategies to support their work plans with IDPH.

Health Care Systems Technical Assistance:

Components to providers participating in VBP arrangements

The IHC will align the SIM TA strategies with Payment Reform processes at play in Iowa (ACOs, APMs, and MIPS). The resources provided will be used to align and transform Iowa's statewide delivery system. Those resources will include metrics to advance provider effectiveness in MIPs and APMs, conducting a series of learning events and webinars, as well as on sight assistance throughout AY3 and AY4.

- Dedicate and deploy resources through SIM liaisons and coordinators, with a focus on provision of analytics and data reports.
- Convene and facilitate meetings to align strategies and resources, including discussions about statewide strategies and common measurement for payment reform initiatives in Iowa.
- Implement the Community Scorecard for non-C3 hospitals to promote community health planning and process improvement.
- Train providers on MACRA, VBP, APMs
- Promote the value and use of SWAN, HRAs, and IHIN and connect provider resources to use of these SIM initiatives.

Additional Components:

- Evaluation to assist in sustainability and support provider level changes (APM Target)
- Focused improvement activities: Action Plan – Priority/Change Management Areas
- Patient engagement, cultural competency, community outreach, collaboration, cost assessment and payment methodology (All Targets)
- Dissemination of emerging ACO information & programs via ACO liaisons (APM Target)
- Evidence-based Peer Learning sessions to mitigate silos and motivate providers to be accountable for deliverables (Readmissions & ED visit Targets)
- Workflow efficiency & risk management through transformational QI coaching (All targets)
- Reduce overlap and duplication through incorporation of support activities across multiple payers (All targets)

The vision for health care transformation can be articulated as, "Healthier Communities, Better Care and Smarter Spending." This will be the overall focus of SIM technical assistance strategies, and will advance community engagement and provider and health systems alignment. The overall aggressive health systems TA strategy will be influenced, shaped and supported by State SIM leadership, the SIM Roundtable participants, and key SIM partners.

See Section C for detailed milestones, action steps and dates of the activities related to **how** Iowa will utilize Technical Assistance within Delivery System Transformation.

7. Sharing Raw Claims/Encounter Data with ACOs

Medicaid began sharing claims/encounter data with the ACOs in October of 2014, during the implementation of the Iowa Health and Wellness Plan ACO program. ACOs expressed a need for payers to provide claims data that enabled them to perform internal analytics on cost and quality and that allowed them to match administrative claims data to the clinical data within their own systems in effort to identify system improvement that help performance on value based contracts.

How it Works:

Medicaid sends a set of standard files to ACOs via their analytic vendor, 3M. The files are transferred through a secure FTP site operated by 3M and each ACO logs in and downloads the files to their own network. The ACOs each have internal processes to integrate the data into their own unique analytic tools. New claims/encounter data files are sent to ACOs monthly, but are dependent on the refresh cycle of the VIS and TCOC dashboards.

Each refresh cycle of data starts with the Medicaid compiling FFS and MCO encounter data received to-date. The data is standardized into the specifications outlined by 3M and securely transferred to 3M. They process the data, perform quality checks, and then apply the business rules to attribute members to ACOs and MCOs, establish the risk adjustments, and calculate the VIS quality measures and TCOC. Once the online dashboard is refreshed in production, a set of claims/encounter data is compiled for each Medicaid ACO and delivered via the secure FTP process.

Current Reality:

Medicaid Claims data sharing with ACOs has paused, while the state established the new Managed Care program with three new companies. The last set of Medicaid data shared with providers was claims/encounters received by 3/31/2016, and made available to ACOs in June 2016. 3M is currently processing claims/encounters received by 9/30/16 (the first set of data using the three new MCOs) and anticipate releasing a new VIS score in May of 2017. Monthly refreshes (roughly every 5 to 6 weeks) is anticipated here after.

Wellmark conducts a similar process using 3M for their ACO provider groups. Medicare also shares claims data with providers in their ACO programs. Although the Medicare claims sharing process is not as frequent.

AY3 Activities:

- Refresh the VIS dashboard into production, and send a new set of raw claims data to each Medicaid engaged ACO by May 2017.
- Work with ACO providers to ensure they are accessing the data and that it includes the elements they need to perform their internal analytics.
- Maintain the data sharing agreements and File layout specifications

c. Essential Delivery System Reforms and their Impact on Patient Care

Iowa's State Innovation Model proposes two primary drivers that will lead to our Vision: "Iowans Experience Better Health and Have Access to Accountable, Affordable Healthcare in Every Community." Those drivers are Payment Reform and Delivery System Reform. Among the many challenges affecting the project, a major challenge that has a high potential for derailing progress is lack of engagement and participation in the activities that support transformation.

In an article published by Health Catalyst, the authors discuss the complications experienced by healthcare organizations in their implementation of quality improvement initiatives. They reiterate the complexity of these changes and the requirements for implementing them; stating systems can feel "overwhelmed." (Falk & Tinker, 2016)[13]. They suggest the following list of 5 Essential Elements for successful quality improvement:

- Adaptive leadership, culture, and governance;
- Analytics;
- Evidence- and consensus-based best practices;
- Adoption; and,
- Financial alignment.

This framework serves as a guide for expressing the delivery system reform work proposed in Iowa's SIM, and sharing the intended results of that work. The following table shares the activities proposed within the Delivery System Reform driver. These activities (Inputs or Practice) represent 3 of the 5 Essential Elements categories from Falk and Tinker's report. The associated result (or Care Delivery Change) is noted in the far right column. This table will articulate the intended changes in delivery based on SIM activities that provide technical assistance and tools to assist with this transformation.

[13] Falk, L. and Tinker, A. (2016). The top five essentials for outcomes improvement. Retrieved from https://www.healthcatalyst.com/Outcomes-Improvement-Five-Essentials

Figure 12: Essential Delivery System Reform/Impacts on Patient Care

Essential Delivery System Reforms and their Impact on Patient Care			
Input: Practice	**Category**	**Result: Care Delivery Change**	**Providers Impacted**
1. SWAN	Communication, Analytics, Technology	Aid providers engaged in VBP to improve care coordination for members during critical transitions (admissions, discharges, and transfers). Improved coordination during transition has proven to reduce readmissions and improve outcomes by catching medication errors and synchronizing care plans from multiple specialty providers. Getting the right information to the right provider in a timely manner also reduces unnecessary spending within the healthcare system. Health systems utilize SWAN alerts for care coordination by integrating the daily alert file into their HER workflow. The SIM grant Award Year 3 activities will focus on improving the local utilization and statewide adoption of SWAN alerts.	Currently available for Medicaid ACO provider groups, however the state aims to open SWAN to any willing provider participant. In 2016 all five Medicaid ACOs received SWAN Alerts. In 2016, all five Medicaid ACOs received SWAN Alerts. As of 1/31/2017, 22,861 SWAN alerts were delivered to providers.
2. Statewide Strategy Plans	Adaptive Leadership, Culture, and Governance	These initiatives are intended to 1) enhance care coordination and transitions for both providers and patients by identifying population risks and addressing barriers to health such as social determinants of health by connecting patients (and providers) to community resources, and 2) develop and implement locally-identified tactics from the statewide strategies to address a specified health condition.	Public documents available to any provider. Specific Technical Assistance to implement is currently focused with C3 communities and ACO providers
3. Community Scorecard	Communication, Analytics, Technology	Identification and prioritization of community health and high cost issues; Tracking of inputs and investment; Monitoring quality of services/projects; Generating benchmark	Available to providers engaged with C3 communities and SIM Healthcare TA for ACO providers

		performance criteria that can be used in resource allocation and budget decision; Comparison of performance across facilities/districts: Mechanisms of direct feedback between providers and users; Building local capacity: Strengthening patient and client voice and community empowerment.	In 2015, there were 54 out of 116 unique tax IDs participating with a C3 community.
4. Health Risk Assessment and Social Determinant Question Alignment	Adoption	Data is aggregated and shared widely for use in planning Individual data triggers interaction from the physician and referrals to C3s and community-based organizations for care coordination and intervention in social needs Use of the HRA and data can be linked to VBP arrangements (Health Confidence scores are linked to payment incentives) Use of a risk assessment and social determinant questions is shared by other Iowa payers and organizations	HRA tools are available to all provider and payer groups.
5. Community and Clinical Care Initiatives (C3s)	Adaptive Leadership, Culture, and Governance	Implementing innovative strategies and referral processes to meet the clinical and social needs of a defined population. Organizes resources and builds processes to identify target population (diabetes) and to improve care coordination for social services (SDH) to reduce unnecessary ED and Readmissions.	Limited to providers geographically located in a C3 Awardee area. In 2015, there were 54 out of 116 unique tax IDs participating with a C3 community.
6a. Community and Clinical Care Initiatives Technical Assistance	Adoption	Utilization of standard language Provision of targeted education Cross-sector commitment to quality and change	TA for C3 providers is limited to providers located in a C3 community and those that are willing to participate In 2015, there were 54 out of 116 unique tax IDs participating with a

			C3 community.
6b. Health Care Technical Assistance	Adoption	Developed new systems of care with Triple Aim-focused Technical Assistance aligned with Payment Reform Strategies Individual data triggers interaction from the physician and referrals to C3s and community-based organizations for care coordination and intervention in social needs	This is a new activity for Award Year 3 and is limited to the three large health systems in Iowa to be successfully in APMs with Medicaid. However, TA is also available to other provider groups through Statewide learning events, recorded Pod Casts, Webinars, TCPI, and HIIN.
7. Sharing Raw Claims/ Encounter Data with ACOs	Communication, Analytics, Technology	ACOs expressed a need for payers to provide claims data that enabled them to perform internal analytics on cost and quality and that allowed them to match administrative claims data to the clinical data within their own systems in effort to identify system improvement that help performance on value based contracts.	Limited to providers engaged in the Medicare ACO program using. In 2015 all five Medicaid ACOs received regular sets of claims data.

d. Quality Measure Alignment

The Medicaid Quality Steering committee convened in fall of 2016 consists of key leadership staff within the Medicaid Agency, including the Medicaid Director and the Medicaid Medical Director, and Division Administrators for Mental Health and Disability and Child Welfare. This group looks at quality across Medicaid programs in an effort to align initiatives and improve health outcomes for the Medicaid members. Core functions of this group include:

- Recommend measures and provide ongoing monitoring of dashboard and key performance indicators.
- Review and revise Quality Strategy Plan for Medicaid Managed Care Program
- Review MCO performance improvement projects and make recommendations for enhancements

As discussed earlier, the broader Innovation and Visioning Roundtable discusses payment and delivery system reform efforts. Medicaid is part of the roundtable to ensure the Medicaid Quality Steering is aligned with the broader healthcare movement in Iowa.

Quality Tied to Payment

Initiatives in Action:

Wellmark rolled out the Value Index Score (VIS) within their VBP program (a quality score linked to payment) in 2012. Medicaid followed with the VIS framework in 2014 for a VBP program aimed at the Medicaid Expansion group. Both payers use the VIS, which consists of 16 measures across 6 domains, risk adjusted and rolled into a composite score based exclusively on claims data. The VIS incorporates 12 months of claims data, creates a longitudinal record for each member and attributes each member to a PCP based on attribution rules (assigned PCP, or if no PCP assignment, looks at a plurality of PCP visits over the 12 months). The analytics allow a PCP to compare their performance against their peers, allow a group (Tax ID) compare their performance to other groups, and allow ACOs (a defined group of Tax IDs) to compare their performance to other ACOs. The analytics are updated every month using an online secure login dashboard. These monthly updates allow providers, groups, and ACOs to not only compare to their peers, but also track trends for quality improvements that are directly linked to their performance in VBP contracting, which links performance in quality to payment.

Medicaid began to incorporate an MCO-level view into the VIS dashboard in 2016 so their populations can be analyzed at this payer level and allow the organizations to track ACO performance for their VBP contracting arrangements with the delivery system. It has taken longer than originally anticipated to process MCO encounter data, thus delaying the refresh of the VIS/TCOC dashboard since the implementation of Managed care, which was noted earlier in this plan. The MCO encounter data began a testing and validation process in September of 2016. The next dashboard refresh is now scheduled for April of 2017. Medicaid will produce a monthly dashboard for ACO and MCO providers throughout 2017, 2018 and 2019 to inform quality in VBP programs that are linked to payments.

Based on feedback from providers, Iowa is rolling out a revised version of VIS (version 2.0) that improves issues around transparency and interpretation of the date by providers. The measures, the domains, and the online reporting tool remain the same, however benefits for the new version include:

(1) **Transparency** – Providers will understand their measure scores based upon their "completion rates". All dependencies on "how others performed" or "how varied the data was" are removed.

(2) **Direct Group Scoring** – The same set of thresholds will be used to evaluate any population directly, specifically, Physician Groups, ACOs etc. Previously, scores needed to be based upon the performance of individual providers that received a VIS score. Now, all providers belonging to a group will have their attributed population contribute to the group score(s).

(3) **All Providers can score well** – If all providers perform in the upper threshold, they will receive excellent scores. Previously, the system was designed so that for every winner there was a loser with respect to a score.

Although Medicare uses a different set of quality measures for their ACO programs (MSSP and Next Gen) there are several areas of alignment as previously identified in Appendix A,

Accountable Care Models, a comparison between Iowa's VIS measures and the MSSP was submitted to CMMI in the fall of 2014. With the implementation of MACRA, Iowa is working on ways to add clinical quality measures from the Quality Payment Program into APM models offered in Iowa. This will further align programs and allow providers to get to scale for true sustainable transformation. Please see the HIT Improvement Plan in Appendix D on the development of a glide path to incorporate clinical quality measures into a VBP program. Some of those details for a glide path include:

- Conduct work sessions with providers to identify a set of CQM measures that reflect quality and should be linked to payment in a system moving from volume to value (align with pop health goals and comparable to MIPS).
- Develop a mechanism for providers to report selected clinical measures to Medicaid
- Reporting would be voluntary in 2017
- Reporting would be requirement in ACO contracting for 2018 (without a quality threshold)
- Reporting would be required and a quality threshold established for 2019

Initiatives in Process:

Statewide Use of a Health Risk Assessment:

Medicaid initially identified January 2016 as the start date to introduce a Member Experience Survey into VIS scoring. The state decided to not implement the VIS Member Experience domain later in the year due to the implementation of Medicaid Managed care. Iowa continues to evaluate member access and quality at the program level (see Special Population Measures below) as alternatives to collecting member experience measures are explored. For example, measuring a member's health confidence and collecting social determinants data regularly is another way to gain insight into patient needs and identify opportunities to engage them in their care. Sharing this data with providers and their partners ensures planning for improved outcomes both individually and in the population. Medicaid is planning a path to collect and link results of a Health Risk Assessment that includes a measure of health confidence and asks Iowa-specific social determinant questions in six focus areas. Conversations have begun with Wellmark and Iowa's Healthiest State Initiative and other organizations to increase utilization of the AssessMyHealth tool within the general population, as noted in the previous section. These activities could lead toward linking member experience data and performance to payment based on the maturity and reliability of the data as we move toward.

Clinical Quality Measures

To achieve A-APM model in Iowa, the collection of clinical quality measures (in addition to the administrative measures from VIS), is a new component of the definition of quality for Iowa. During AY3 the state will implement activities that identify infrastructure and quality measures that are comparable to MIPS to be used in an A-APM model to support future programs within Iowa. The state will implement a pilot program to report clinical quality measures from providers engaged in the Medicaid ACO program (with one or more MCO). Reporting in AY3 will initially be voluntary while subsequent years will be mandatory.

Specific details on the how the state is planning for infrastructure and implementation can be found in the HIT Improvement Plan, Appendix D.

Special Population Measures

Medicaid has begun the work of tracking vulnerable populations unique to the Medicaid market through the use of administrative claims data. Medicaid spent a great amount of time in 2016 working with our analytic vendor to establish a set of measures to assess both access and quality for these special subpopulations and a method to (monthly) monitor MCOs performance in safeguarding this population.

The measures were selected based on a series of meetings with Iowa Medicaid subject matter experts in long term care services and supports (LTSS), child and adult services, the Medical Director and in consultation with 3M experts in collection and analytics. The state believes this set represents key areas to monitor access and quality. The list will be evaluated annually and updated as needed. Tracking these measures has the potential to impact SIM goals to reduce ED Visits and Readmissions though targeted process improvement work based on outcomes.

The measures are baselined using Medicaid data from calendar year 2015. From there, the measures will be reported with each data cycle (roughly monthly, starting in May of 2017) to monitor variation between MCOs and variation from the Medicaid baseline. The monitoring of these measures will help guide policies and future contracts and incentive programs between the state and the MCOs.

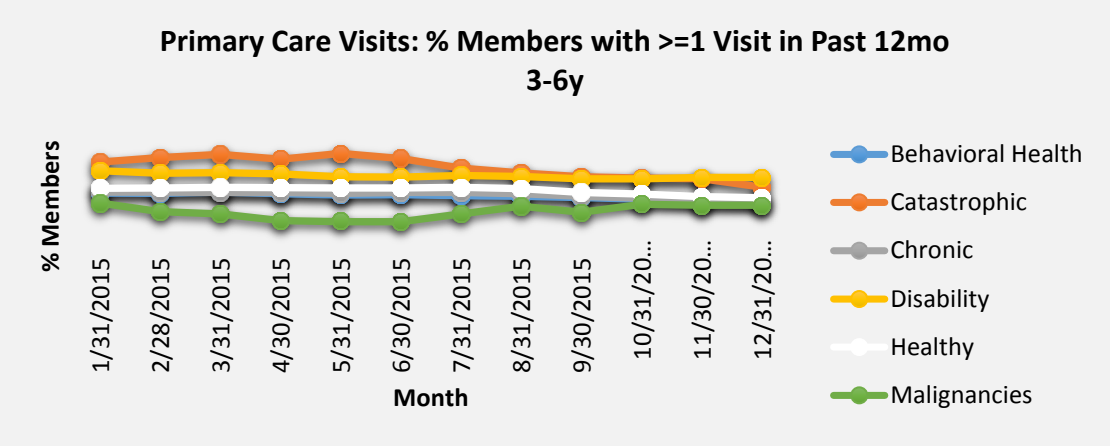
As Medicaid monitors the MCOs performance on these special population groups, a Medicaid Quality Steering committee initially convened in the fall of 2016 will address what measures need to tie to an MCO performance withhold payment and what measures should apply to value-based programs and APMs in Iowa. This data

Figure 13: Special Populations tracked across MCOs

Special Populations *(Individuals may count in multiple categories)*
Children with Behavioral (defined by CRG)
Children with Behavioral (defined by Medicaid program)
Children with Chronics (excluded malignancies)
Children with Malignancies
Children with Disabilities (defined by Medicaid Programs)
Child Welfare
Juvenile Justice
Healthy Children
Adults with Behavioral (defined by CRG)
Adults with Behavioral (defined by Medicaid Program)
Adults Chronic (excluded malignancies)
Adults with Malignancies
Adults with Disabilities (defined by Medicaid Programs)
Adults with Disabilities (defined by CRG)
Healthy Adults
All Pregnancies
High Risk Pregnancies

A run chart for each measure containing a line for each special population group will be produced monthly and shared with the IME. The IME can monitor the performance of each MCO against the measures and for each special population. An example of a 2015 baseline chart is found below. Baseline data is the last 12 months period before managed care implementation (1/1/15 through 12/31/15) and contains a mean for each measure for each special population.

Figure 14: Example Baseline Special Population data



e. Roadmap to Improve Population Health

The comprehensive plan for improving population health in Iowa can be found in Appendix E.

The Iowa SIM Roadmap to Improve Population Health will focus on decreasing the prevalence and incidence of diabetes in Iowa. Diabetes is a chronic illness that is diagnosed based on a person having elevated levels of blood sugar (blood glucose). Most people with diabetes find its management challenging and a lifelong commitment. But, people with diabetes can live normal and healthy lives and avoid many, if not all, of the complications of diabetes. The Iowa SIM project will positively impact health outcomes for the approximately 211,000 Iowans who live with diabetes, the nearly 200,000 with pre-diabetes, and the estimated 9 out of 10 adults with prediabetes that don't know they have it.

The framework that Iowa will use for population health improvement encompasses the following three main components:

- System-level Care Coordination & Management,
- Evidence-based Care and Patient Self- Management and Support, and
- Linkages to Community-Based Resources to Address Patients' Social Needs.

System-level Care Coordination & Management

Care coordination for the target population will be enhanced through 1) focusing provider efforts on improving health outcomes for diabetes in pilot communities (C3s) by enhancing the existing value based payment structure to include clinical quality measure(s) potentially related to diabetes care; and 2) having a health information technology infrastructure that supports care coordination that includes:

a) Alerting notifications for inpatient admissions/discharges and emergency department admissions (SWAN);
b) Fully utilizing the querying and direct secure messaging IHIN functionalities to facilitate efficient and secure communication and closed loop referrals;
c) Requiring local IT systems to support care coordination of social needs within C3 pilot communities; and,
d) Providing a data system to the C3 pilot communities to assure continuous process improvement.

Evidence-based Care and Patient Self- Management and Support

Learning how to manage diabetes is very important to those who have the condition to keep it from leading to deteriorating health. Preventing and managing co-occurring conditions and monitoring care during health care transitions are important functions of the healthcare delivery system and community-based organizations. To improve health outcomes for individuals with diabetes, the Iowa SIM project will educate local pilot communities and healthcare providers on national diabetes guidelines and tactics from the Iowa-developed statewide strategy plans.

The Iowa SIM project will increase the intensity and geographical spread of the tactics contained in the Diabetes and other statewide strategy plans through the 1) C3 "population based, community applied" interventions, and 2) promotion of the tactics to communities

identifying diabetes as a need in their Community Health Needs Assessment and Health Improvement Plans (CHNA &HIP). Tactics from the other statewide strategy plans, such as Medication Safety and Effectiveness and Care Coordination, will be used to address specific aspects of diabetes care to further enhance the implementation of the interventions included in the Diabetes Statewide Strategy Plan.

Community and clinical linkages to four evidence-based group programs will be strengthened in C3 pilot counties through facilitated process improvement cycles that create or enhance existing referral systems. There are currently 90 state-certified diabetes self-management programs in Iowa. For individuals who have recently been through the state-certified DSME program or where payment is a barrier, they may be referred to two other low or no-cost self-management programs. Iowa has a network of trained leaders for the Stanford Chronic Disease Self-Management Program (CDSMP) across the state. Alternately, Telligen is a collaborative partner that provides the "Everyone with Diabetes Counts" program to local communities throughout Iowa. The infrastructure for all three programs is available and will support increased referrals. Lastly, the National Diabetes Prevention Program is and will continue to expand in C3 counties.

To assure statewide alignment for evidence-based care and patient self-management, the Iowa SIM program will enhance existing statewide efforts in the areas of data, programs and policy. Innovative processes learned, resources developed, and clinical measures collected during the three SIM model test years will be integrated into the 2021 Community Health Needs Assessment & Health Improvement Plan process, when possible to sustain interventions beyond the SIM project period. The Iowa SIM team will seek to address payment barriers that limit attendance to evidence-based programs or don't align with national guidelines.

Linkages to Community-Based Resources to Address Patients' Social Needs

Social systems and physical environmental supports are essential to the success of Iowans' individual efforts to prevent and control diabetes. Research, evidence-base practice, and anecdotal observations indicate linking clinics to community service agencies at the clinical entry point through effective referral processes is critical to addressing social determinants of health (SDH).

The Iowa SIM project will address SDHs in three ways. 1.) The development and/or enhancement of referral networks, in C3 regions, that address social needs for individuals having or at risk of having diabetes. Technical assistance will be provided to the C3s so the referral systems that are implemented are effective and efficient. 2.) SDH interventions will be implemented in the Iowa SIM project is through expanding the use of the Assess My Health (AMH) health risk assessment (HRA) by linking it to value based purchasing for the Medicaid Managed Care Organizations with special attention to the Health Confidence measure. Expansion to additional payers or to the general population is also being explored. 3.) The aggregated SDH data collected from the AMH completion will be shared with stakeholders to inform decision makers about the SDH needs across Iowa.

Initiatives in Action:

For more details on how Iowa will improve the health of Iowans living with diabetes, refer to the 1) Roadmap to Improve Population Health in Appendix E; 2) the action plan tables in Section C of the Operational Plan; and 3) the Health Information Technology plan in Appendix D.

f. Health Information Technology

Iowa recognizes the need to create a framework to support the move from volume to value, as well as the need to establish information management protocols. Iowa's goal during Award Year 3 of SIM is to plan, develop, and implement the necessary technology and infrastructure to promote the exchange of information to improve service delivery.

Iowa will conduct a Provider Readiness and Health IT Infrastructure survey to obtain a true picture of what capabilities and gaps may exist in Iowa. The results of the survey should help us plan solutions that clearly outline our value propositions and the next steps for implementation.

Focus areas for the Provider Readiness survey include:

- Provider EHR Certifications & Capabilities
- Barriers to Data Extraction from EHRs
- Financial Barriers
- Workflow Barriers
- Input on a set of Core Clinical Quality Measures that should be included

Focus areas for the Health IT Infrastructure survey include:

- Assessment of the current technical infrastructure available in Iowa
    - Data Collection ability
    - Data Aggregation ability
    - Analytics
    - Reporting Services
- Financing
- Governance
- Sustainability

HIT Data Flow to support Delivery System Reform

The HIT Enhancement Planning document (Appendix D) lays out a series of data flow diagrams that illustrate both current and future infrastructure in Iowa. Below are use cases on how the data infrastructure is used (or will be used) to support delivery system reform.

Current Landscape: Medicaid Quality Measurement and VBP Incentives

The state has invested in an analytic vendor to process claims/encounter data, run attribution, establish risk adjustments, and expected values and produce a quality score VIS to inform value based payments. The Value Index Score (VIS) 6 domains covering 16 measures of key processes and outcomes that leads to value in healthcare.

Providers and Payers have access to a secure online dashboard that provides comprehensive information on how the Value Index Score and Total Cost of Care are calculated.

1. A provider submits claims data to payers, through the normal process to receive payment for services.
2. MCOs send comprehensive data set to Medicaid agency monthly
3. Medicaid processes the data files into a standard file format and submits to the Analytic vendor, 3M
4. 3M completes an additional validation process including attributing members to the Primary Care Provider and MCO of assignment
5. 3M produces a Value Index Score (VIS) and Total Cost of Care calculation that is shared with the delivery system through the secure online dashboard.
6. Providers/ACOs that are engaged in Value-based purchasing contracts with any of the 3 MCOs are paid an incentive as outlined in their agreement with the respective MCO.
7. To qualify as VBP agreement as defined within the MCO contracting with the State, VBP contracts between an ACO and MCO must include the use of the state defined set of risk adjusted quality measures, Value Index Score (VIS) and Total Cost of Care (TCOC) Methodology.

Service Delivery and Care Coordination

To date SWAN has been a major advancement in the use of Health IT Infrastructure because of SWAN's ability to inform care coordination and inform a provider in closing a referral loop. Please look at the SWAN system information in this document here.

1. A member presents at the ER with chest pain.
2. Providers at the hospital can Query the IHIN to gain additional information about the patients' health history.
3. The event automatically generates an ADT file that is filtered through the IHIN.
4. The SWAN alert provides basic information about the member – including Chief Complaint and Primary Diagnosis. In this case the member was diagnosed as having a Panic Attack; the alert was sent to the members ACO & MCO of assignment.
    a. The MCO has a Care Coordination Team who reaches out to the member to discuss additional value added services that might be beneficial to the member.
    b. The ACO forwards the alert to the member's primary care physician schedules a follow up appointment to address ongoing management of their anxiety.
        i. During this appointment the member states that they have recently lost their job and are worried about supporting their family.
5. After the member has met with the primary care provider it has been determined that the member might benefit from some additional support from the community regarding food and housing. The Care Coordinator at the clinic makes a referral to the C3 organization.
6. The C3 organization reaches out to the member and coordinates referrals and assistance to the local food bank and housing authority.

7. Because of the SWAN Alert the member has been able to receive the medical care necessary to treat his anxiety but he has also been able to receive additional services and supports needed from the community.

The HIT Improvement Plan can be found in Appendix D and describes the current framework and planning efforts to enhance HIT use and infrastructure during AY3.

g. Workforce Capacity

The Iowa SIM team will be working alongside existing workforce initiatives in Iowa to align Iowa's workforce capacity with payment reform. The Iowa Department of Public Health is supporting an environmental scan to inform workforce capacity, and has several existing healthcare provider recruitment and retention programs. Specific SIM workforce activities will include training and education to providers on value-based purchasing and payment reform, and resource provision and required training within the C3s. Additionally, IDPH SIM staff will remain engaged in existing programs to assure payment reform is considered and alignment within the C3s. More information on the SIM workforce initiatives may be found on page 9 of the Roadmap to Improve Population Health in Appendix E.

While the State is currently not pursuing the formalizing of the CHW role in health care, the Iowa Chronic Care Consortium has taken a lead on this topic. A pilot training has been developed and will be held in March 2017. A certification program is not being pursued at this time as there is a lack of readiness in Iowa for this type of work. Iowa will follow other states like Washington, where CHWs are recognized but not certified.

MCOs, health care providers, and community-based organizations currently employ frontline health workers under various titles. Work has begun to develop a solid definition and title for this important asset to the health care system. The Chronic Care Consortium is also currently surveying Iowa's CHW stakeholders to gather more information on use, interest, and future needs for this role. They are also planning to fund pilot projects in a variety of communities where CHWs will be deployed and their outcomes measured. A Community Health Worker Alliance has been formed and convenes regularly to guide this work

Refer to the Population Health Roadmap for more information on the Iowa SIM workforce activities.

3. SIM Alignment with State and Federal Initiatives

a. CMCS

Effective April 1, 2016, the Iowa Department of Human Services launched Iowa Health Link. This represented a major strategic shift for the Medicaid program in Iowa, moving a largely fee-for-service program into a comprehensive managed care approach for nearly all members. This approach focuses on whole-person coordinated care consistent with SIM. The contracting for the three, new managed care plans incorporates key SIM design components to maximize the combined effect of driving the strategy through the new Medicaid managed care structure. This includes requirements that the plan contract with the delivery system to reach specific Value Based Purchasing (VBP) thresholds that utilize the common quality scoring tool (the Value

Index Score – VIS) along with total cost of care to measure performance. In addition, MCO incentives align their performance with the VIS, and require PCP assignment to support system-wide alerts among other elements pushing health IT and delivery system transformation.

b. CMMI

There are several examples of CMMI initiatives present in Iowa today. As stated earlier, Iowa providers are engaged in APM and AAPM models available from the Innovation Center, like the Medicare Shared Savings Track 1 and Track 2, and the Next Generation ACO model. Iowa providers are also engaged in TCPI and HIIN programs aimed at transforming the system delivery of care. Much of the work funded by SIM is simultaneously working to ensure maximum alignment with CMMI programs active in Iowa. The Iowa SIM focus is on Payment Reform through APM development (ACO models specifically) with Wellmark and Medicaid and Delivery System Reform through a series of equipping strategies (tools and technical assistance).

There is not activity in Iowa with the Innovation Center's CPC+ program. In 2012 and 2103, Iowa Medicaid implemented two Health Home programs that pay primary care providers for Health Home services. Those programs are progressing and well received by Iowa Providers. Currently, both Health Home programs are implemented through Managed Care. Medicaid considers the Health Home model a foundational building block for successful APM maturity in the delivery system because as providers become better at managing chronic conditions and engaging patient at a local level, health care outcomes improve and costs decrease.

c. State Initiatives

We recognize there are many innovative efforts within our state aimed at transforming our healthcare delivery system and health of our population. SIM initiatives are intended to compliment and reinforce additional efforts that are already underway in Iowa and funded by both federal and state partners. SIM staff will maintain an inventory of other transformative efforts and make every effort to minimize duplication and avoid market confusion.

Quarterly meetings among state partners in innovative work are conducted and attended since early in 2016. These quarterly meetings include representation from the QIN-QIO, TCPI, HEN/HIN, and CDC 1305.

A concerted effort is made to parallel our efforts from existing initiatives and not be duplicative of SIM activities. Referrals and recruitment activities are shared to aid transformation and help technical assistance get to scale without overlap. Because there is an established partnership relationship among these organizations, the work across programs is leveraged to reduce gaps and accelerate transformation. The below table illustrates the close working relationship across the innovation organizations.

Organization	Innovation Work
Iowa Healthcare Collaborative	TCPI Compass TPN HEN/HIIN SIM TA Vendor
Telligen	QIN-QIO TCPI Compass TPN Iowa HIT Regional Extension Center Iowa QPP Small and Rural Practice TA
Medicaid	Iowa SIM Oversite and Medicaid Payment Reform
Iowa Department of Public Health	CDC 1305 SIM Population Health Roadmap SIM Oversite of C3 Development SIM HIT Planning activities

SIM Technical assistance (click here for more detail) is conducted by Iowa Healthcare Collaborative (IHC). The IHC participates in many of the other provider TA activities in Iowa including TCPI, Compass TPN, and HEN/HIIN. Using a common organization for SIM TA and other transformation efforts in Iowa, allows the state to close the gap between these programs and ensure they are all being leveraged for true transformation of the delivery system.

For example, in the Compass PTN Technical Assistance Model, state-based QI Advisors provides ongoing TA to assigned clinics, reinforcing best practices around data sharing, leveraging HIT, and improving processes for quality measures. These best practices are shared in TCPI national webinars and local learning sessions. The Compass PTN QI Advisors use the results from QIN/QIO pre-assessments and on-going assessments (to the extent available), as well as PTN interim assessment tools, to track practices' progress through the phases of transformation. QI Advisors assist clinics to build capability in adopting QI methods (e.g., PDSA and Lean), developing work plans, reporting HIT data, using the results of small change to produce a scale that is sustainable. All Compass PTN QI advisors receive specialized training and education. The training ensures consistency in QI Advisor skill and knowledge, enabling a standard of QI service across the PTN. This specialized training and education is also the foundation for SIM QI advisors as they focus TA toward the C3s and the healthcare systems engaged in APM models from SIM.

A listing of existing transformation initiatives occurring in Iowa is below.

Figure 15: Healthcare Transformation Initiatives in Iowa

Existing QI/Health Reform Effort	Projected Results	How will efforts be incorporated and support SIM?	State, Federal or Privately Funded?
IA QIN-QIO 11th SOW	Reduce leading causes of mortality, Pop. health mgmt., Improve hospital admit/readmit rates, Reduce adverse drug events, Improve patient & family engagement, Support participation in value modifier program	Promote participation in QIO-sponsored programs, Align content and messaging to reduce duplication and market confusion.	Federal
Hospital Engagement Network 2.0 (HEN)/HIIN	Provides hospitals a wide array of initiatives, activities, and technical assistance focused on patient safety and reducing readmissions.	HEN/HIIN resources and data will be engaged when C3 projects are hospital focused. IHC's involvement in both programs will facilitate direct alignment.	Federal
Transforming Clinical Practice Initiative (TCPI)	Provides direct quality improvement support to clinicians, driving real-time, measureable improvement strategies.	Align SIM content to engage TCPI providers and maximize sustainability; use common stakeholders to drive improvement.	Federal
Center for Disease Control and Prevention's 1305: State Public Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health grant	Community strategies to improve hypertension control and/or diabetes management; promote walkable communities; and improve healthy food access.	Collaborate with and enhance existing efforts in participating communities.	Federal
Local Community Partnerships (Smoking and Health initiatives)	Thirty-six Community Partnerships serve 99 of the 99 Iowa counties. The Community Partnerships serve as a resource to individuals, schools, worksites, and healthcare organizations to encourage cessation, reduce second hand smoke exposure, and reduce tobacco use initiation.	Collaborate with and enhance existing efforts in participating communities.	State
Meaningful Use EHR Incentive Payment Program	Providers invest in certified electronic health record systems to achieve interoperability and ultimately better health outcomes at a lower cost.	Providers with high functioning EHR systems have the technology to transform how they deliver care and perform in VBP arrangements.	State and Federal
Section 2703 Health Home	Provide comprehensive coordinate care for members with chronic conditions to reduce ED Visits and Impatient stays will improving the overall health of members enrolled in the program.	Medicaid will promote and track Health Home program growth as a secondary indicator of transformation of the delivery system.	State and Federal
Medicare Shared Savings programs	Deliver System transforms into accountable entities that deliver better quality care at a lower cost. Iowa providers are participating in various tracks. This is not a State funded activity but aligning Medicaid and Wellmark ACO programs with Medicare programs will help providers get to scale. Providers will be given technical assistance to improve their VBP performance which should help them achieve the goals of the MSSP contracts and any other VBP contracts they are participating in.	Medicaid will promote and track VBP program growth as a key indicator of transformation of the delivery system that leads toward sustainability.	Private (investments from the ACO participants) and Federal

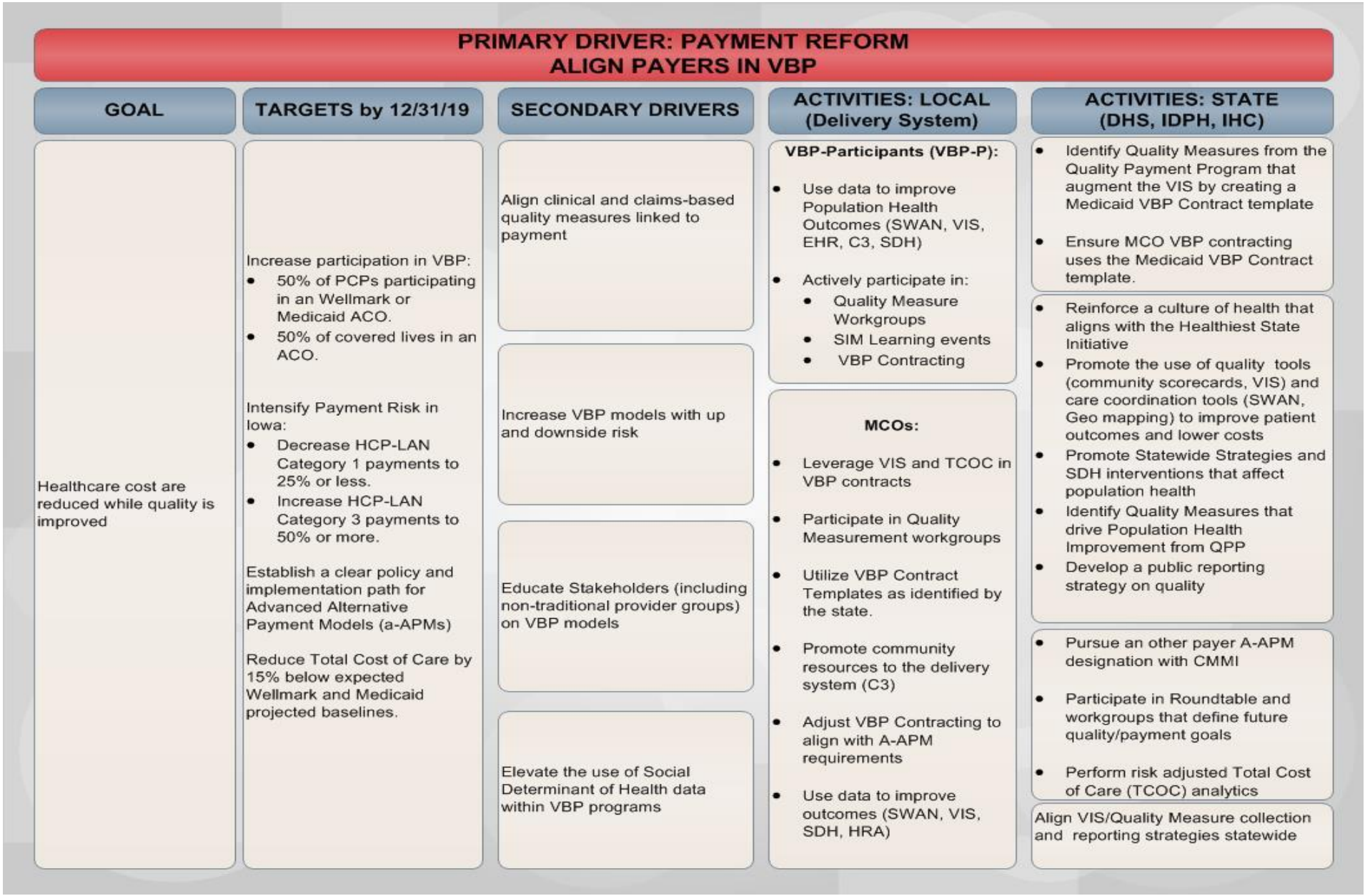
Existing QI/Health Reform Effort	Projected Results	How will efforts be incorporated and support SIM?	State, Federal or Privately Funded?
Community Health Worker Exploration and Training	Results of an assessment will indicate the current landscape and opportunities related to CHWs. Training of 40 CHWs from various payers, health care providers and CBOs will begin to draw attention to the expertise and effectiveness of frontline health workers and ignite interest for policy change. Evaluated pilot projects will speak to the outcomes produced by CHWs. The Community Health Worker Alliance will continue to support moving forward to create an environment where CHWs are embraced in Iowa's health arena.	Two IME members are active participants in this initiative, working closely with the Iowa Chronic Care Consortium and the CHW Alliance. The information from the training, the assessment, the pilot projects and other educational opportunities will be shared with our TA providers and their organizations to distribute to relevant stakeholders in order to connect them with this work.	Private foundations and organization

Section C: Detailed SIM Operation Work Plans by Driver

This section is broken into details of **how** Iowa will use the two primary drivers of Payment Reform and Delivery System reform and specific SIM activities to achieve our goals. A more detailed driver diagram (from the vision driver diagram in Section A) is found for each primary driver that highlights activities at the local level and State level that will advance the SIM objectives during AY3. Preceding the driver diagrams are tables listing specific milestones, action steps, timelines, responsible party and budget linkages. The milestones listed in these tables align with milestones presented in Section A for the Master Timeline section. The Master Timeline section gives more detail on if the milestone is for planning or executing and displays milestones from previous award years. The Master Timeline also includes HIT Activities from the Appendix D and Evaluation Milestones, and Grant Administration Milestones.

1. Primary Driver: Align Payers in Value Based Purchasing

Figure 16: Payment Reform Driver Diagram



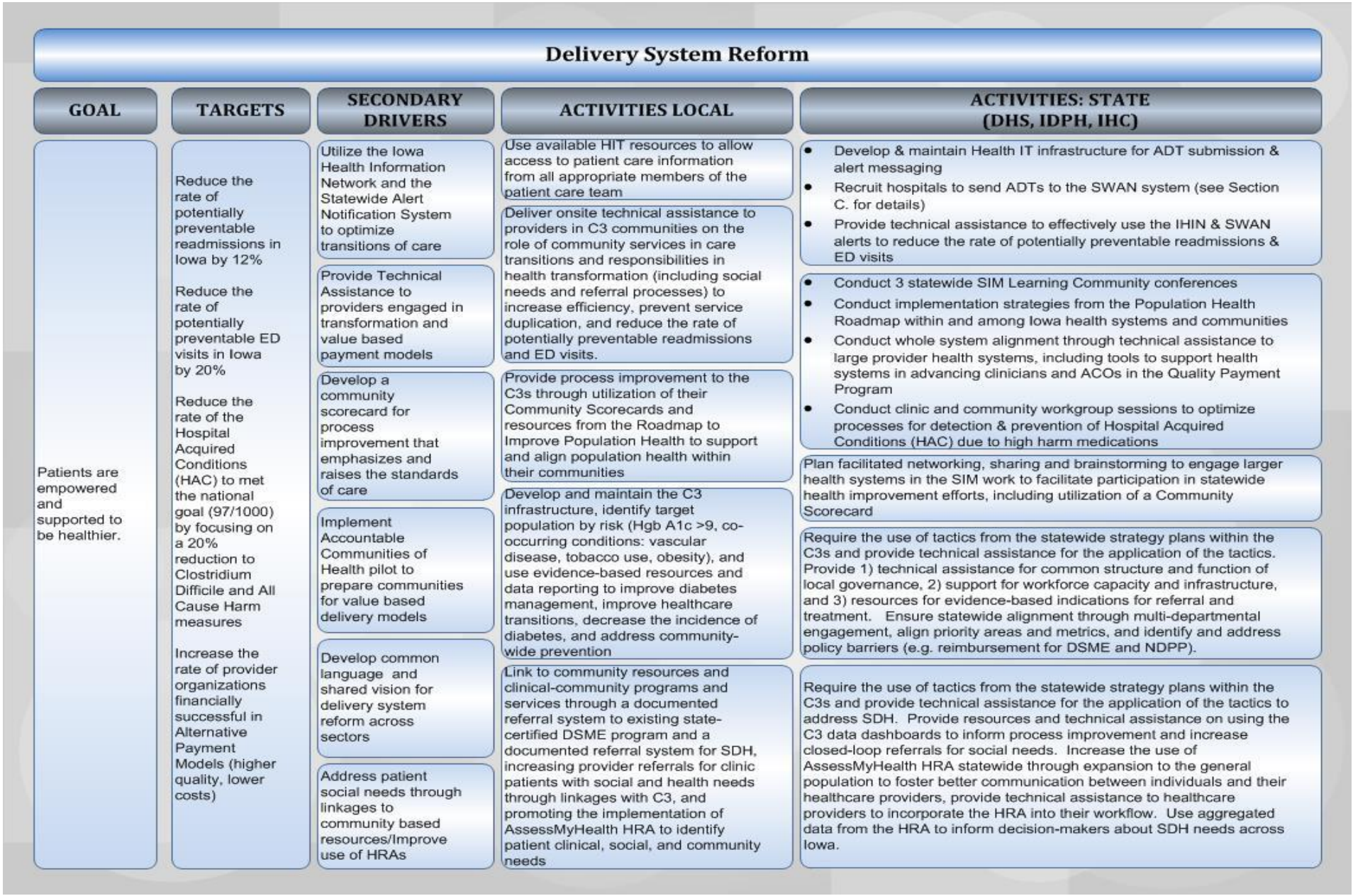
SIM Activity: Implement ACO Aligned Strategy in Medicaid				
Milestone/Measure of Success	**Budget Activity**	**Action Steps**	**Timeline**	**Responsible Party**
Qualify each MCO VBP (incentive based) contracts for 2017	Telligen	1. Issue guidance to MCOs on requirements for 2017 2. Review Contracts, confirm or issue Corrective Action Plans, as needed 3. Hold Informational/Education Meetings as needed 4. MCOs to report data for SIM Core Metrics	March 30, 2017	Medicaid Agency
Update the MCO Incentive Program (July 17 to June 18)to Align with VBP goals	Telligen	1. Develop proposed program with aligned areas (VIS, TCOC, HRA utilization and select special pop measures 2. Review proposal and seek input from the Medicaid Quality Steering Committee 3. Share proposal with and see input from the MCOs 4. Medicaid Leadership approves proposal 5. MCO Contracts amendments updated to reflect executing on the updated Incentive Program	March 30	Medicaid Agency
Publish 2017 VIS baselines score for ACOs and MCOs	Telligen, 3M	1. Send 3M MCO and FFS encounter data 2. 3M to perform Analytics, including quality checks, member attribution, risk adjustment, executing on all business rules using VIS 2.0 framework 3. 3M to refresh the online dashboard 4. 3M to send Medicaid report of baseline results for VIS for Providers, Tax IDs, ACOs and MCO performance 5. Medicaid to distribute data to each party participating in VBP programs	May 30, 2017	Medicaid Agency
Release the Medicaid VBP Contract Template	Telligen	1. Research language alignment areas with other private payers and components of the MACRA QPP program (up and down side risk, use of VIS, CQMs, CEHRT, etc.) 2. Develop internal proposal and distribute (AG office, Medicaid Director, etc.…) 3. Medicaid leadership approves internal proposal 4. Share Contract with MCOs	June 2017	Medicaid Agency
Confirm each MCO VBP Contracts for 2018 VBP program (TCOC and Quality with risk component) to inform VBP program that is at HCP-LAN Level 3A or higher	Telligen	1. MCOs submit contracts with approved language 2. Medicaid agency reviews, confirms and issues Corrective Action Plans, as needed 3. Hold Information/Education Meetings as needed	September 2017	Medicaid Agency

Publish the 2018 VIS and TCOC baselines, targets and Budgets	Telligen	1. Send 3M MCO and FFS encounter data 2. 3M to perform Analytics, including quality checks, member attribution, risk adjustment, executing on all business rules using VIS 2.0 framework 3. 3M to refresh the online dashboard 4. 3M to send Medicaid report of baseline results for VIS for Providers, Tax IDs, ACOs and MCO performance 5. Medicaid to distribute data to each party participating in VBP programs	December 2018	Medicaid Agency
Achieve at least one Other Payer A-APM by 2019	Telligen	1. Identify requirement of A-APM program from final rules (CQMs, CEHRT Technology minimums, finical risk minimums, etc.) 2. Medicaid to establish plan to update VBP program (Overseen by Medicaid, ran through MCO contracts with Delivery Systems) 3. Collaborate with Wellmark on plan toward compliance 4. Identify path to submit Other Payer A-APM status by 2019 5. Iowa Providers have ability to achieve QP status and earn a 5% Medicare Bonus	December 2018	Medicaid Agency

SIM Activity: Managed the Online Quality Tool to support APMs(3M VIS/TCOC)				
Milestone/Measure of Success	**Budget Activity**	**Action Steps**	**Timeline**	**Responsible Party**
MCOs have access to the VIS Dashboard to track quality and TCOC	3M/Telligen	1. MCOs submit reliable encounter data to Medicaid 2. MCOs can view online dashboard at the plan level around VIS and TCOC 3. MCOs can view online dashboard at the ACO level for just their assigned population	May 2017	Medicaid, Telligen and 3M
ACOs have Medicaid Claims/Encounter Data to support internal analytics	3M	1. Refresh the dashboard in production and send a new set of raw claims data to each Medicaid engaged ACO 2. Work with each ACO to ensure data is being accessed and contains elements to support improvements 3. Maintain the data sharing agreements and File layout specifications	April 2018	Medicaid, Telligen and 3M

2. Primary Driver: Delivery System Reform – Equip Providers

Figure 17: Delivery System Reform Driver Diagram



SIM Activity: Population Health (Local): Secondary Drivers of ACH Framework, Addressing Patient Social Needs, Community Scorecards. For additional information, refer to information on C3s in Section II, Appendix E Population Health Roadmap, and Appendix E attachment C3 RFP.			
Milestone/Measure of Success	**Action Steps**	**Milestone Timeline**	**Responsible Parties**
Develop and maintain the C3 infrastructure: All C3s have active steering committee and coalition with the required membership.	1. Work with C3s to ensure all required entities are represented on the steering committee 2. Provide resources to support required goals of the C3 steering committee, including identifying leadership, implementing strategies from the statewide strategy plans, and data sharing 3. Conduct gap analysis on each C3 coalition and provide resources and technical assistance to align each coalition	08/30/17	IDPH
Develop and maintain the C3 infrastructure: All community-based care coordinators complete the Options Counselor training	1. Provide options counselor training info to all C3 contractors 2. C3s to provide documentation (TBD) that all community-based care coordinators listed in the personnel form have completed training 3. C3s to provide documentation of completed training within four weeks of hiring new community-based care coordinators	10/31/17	IDPH
Develop and maintain the C3 infrastructure: Assessment of the role and training needs of all C3 community-based care coordinators completed	1. Assess training needs of all C3 care coordinators 2. Analyze results of assessment	07/31/17	IDPH
Develop and maintain the C3 infrastructure: Workforce training identified and provided to all C3 community-based care coordinators	1. Research available training and resources based on workforce needs identified 2. Community-based care coordinators complete identified required training 3. Required training is identified in the continuation application for year 4	12/31/17	IDPH
Develop & maintain C3 infrastructure and Link to community resources and clinical community programs and services: Two C3 contractor meetings held for contract updates and to promote networking, sharing, collaboration, training, and education.	1. Identify venue, schedule meetings 2. Develop agenda, identify speaker(s) as applicable 3. Plan facilitated networking, sharing, and brainstorming	11/30/17	C3s/IDPH

Develop & maintain C3 infrastructure: Assessment completed of C3 CHNA & HIPs with required tactics in the C3 action plans	1. Review all CHNAs for alignment with the target population 2. Review HIPs for alignment with required tactics in the C3 action plans 3. Facilitate work session with each C3 to identify the capacity to align CHNA/HIPs with the target population and required tactics 4. Provide TA to each C3 to align LBOH HIPs with required tactics during the yearly HIP update 5. Facilitate collaboration between hospitals and public health on CHNA/HIP process, when needed.	07/31/17	1. IDPH 2. IDPH 3. IDPH 4. IDPH 5. IHC/IDPH
Create unique tracking and value calculation for diabetic patients with A1C>9 with vascular disease, tobacco use and obesity.	1. Facilitate the develop of a process with C3s for populations within their communities that are at higher risk, and where possible 2. Create unique tracking and value calculations for these groups 3. Monitor process and tracking throughout the award year		IHC
Use evidence-based resources and data reporting to improve diabetes management: Utilize ACH structure to assist with process advancement of community-selection diabetes management activity	1. Utilize community assessments 2. Facilitate leadership group meetings to determine commitment (e.g. Diabetic management) 3. Identify and inform C3s of local and SIM resources to equip local community alignment 4. QI Advisors and IHC faculty will review assessment tool results and assist with process advancement	12/31/17	1. IHC/IDPH 2. IHC/IDPH 3. IHC/IDPH 4. IHC
Use evidence-based resources and data reporting to improve diabetes management: C3s complete at least one process improvement cycle based on analysis of data to improve diabetes management (i.e., diabetes management, adverse drug events related to diabetes, 30-day readmissions, preventable ED visits, and protocol/process for foot exams.)	1. Collect data outlined in the RFP 2. Provide TA on process improvement cycles 3. Document PDSA cycles in IHC reports 4. Develop local Community Scorecards to advance C3 performance 5. Support C3s in utilization of their Community Scorecards and the Population Health Roadmap resources to support and align activities to address population health in their communities 6. Support C3s in use of the statewide strategies addressing population health topics to identify tactical activities and partners to address as a community 7. Promote C3 utilization of the Iowa Report to increase access to community health data affecting population health	11/30/17	IHC
Use evidence-based resources and data reporting: Maintain the current C3 SIM Data Portal	1. Manage and build SIM Data Portal capacity 2. Compile integrated clinical and C3 community data 3. Develop and provide quarterly C3 Community Score Cards based on SIM portal data analytics 4. Provide virtual training for data analytics and data communication skills	04/30/18	IHC

	5. Provide monthly TA for quality and process improvement (e.g. PDSA) 6. Continue to review the C3 process measures and QI Work plan submitted by C3 7. Provide quarterly QI work plan analysis reports to C3		
Improve healthcare transitions: C3s have assigned roles within the healthcare team for care transitions	1. Identify roles within the healthcare team 2. Provide TA on care transition best practices and process improvement 3. Develop a process map or flow chart to demonstrate roles in the healthcare team 4. Collect and report clinical quality measures for process improvement	10/31/17	1. C3s/IHC 2. IHC 3. IHC 4. IHC
Link to community resources and clinical-community programs and services: C3s have documented referral system to existing state-certified DSME program and NDPP and are actively referring	1. Review C3 action plans for existing referral systems 2. Conduct additional assessment of existing referral systems and existing DSME and NDPP, as needed 3. Provide TA to assist C3s in developing DSME and NDPP, where needed 4. Provide TA to develop referral systems and feedback loops	12/31/17	1. IHC 2. IHC 3. IDPH 4. IHC/IDPH
Link to community resources and clinical-community programs and services: C3s have documented referral system for SDH and are actively referring	1. Review C3 action plans for existing referral systems 2. Conduct additional assessment of existing referral systems, including community care coordination health IT systems, as needed 3. Provide TA to develop referral systems and feedback loops using HIT 4. Collect SDH data and enter into the IHC data portal 5. Manage and build SIM Data Portal capacity 6. Compile integrated clinical and C3 community data 7. Develop and provide quarterly C3 Community Score Cards based on SIM portal data analytics 8. Provide virtual training for data analytics and data communication skills 9. Provide monthly TA for quality and process improvement (e.g. PDSA) 10. Continue to review the C3 process measures and QI Work plan submitted by C3 11. Provide quarterly QI work plan analysis reports to C3		C3s/IDPH/ IHIN/IHC

SIM Activity: Healthcare Systems Technical Assistance			
Milestone	**Action Steps**	**Timeline**	**Responsible Parties**
Conduct 3 statewide SIM Learning Community conferences	1. Continued coordination of all aspects of the event including; a. Logistics b. Determining topic and speakers to focus on SIM goals c. Marketing and registration d. Accreditations e. Evaluation	05/31/17 – 02/28/18	IHC
Conduct implementation of population health strategies within and among Iowa health systems and communities	1. Convene work group sessions for implementation and execution of statewide strategies to advance population health 2. Convene discussion groups for development of common, unifying language and messaging around population health, the Advanced Communities of Care model, and value-based system transformation (including the QPP) 3. Promote the use of HIT tools, like SWAN, HRA, Direct Secure Messaging, data sharing and analytics (community scorecard) as methods to meet quality measure goals for VBP.	06/3017-04/30/18	IHC IHC IHC
Conduct whole system alignment through technical assistance provided to larger provider health systems	1. Convene workgroups to develop and implement a statewide strategy for Health System alignment, prioritizing statewide standards of care. 2. Plan facilitated networking, sharing and brainstorming to engage larger health systems in the SIM work to facilitate participation in statewide health improvement efforts, including utilization of a Community Scorecard 3. Explore common management strategies for unique higher risk populations, including identification, tracking, and value calculation 4. Convene workgroups to develop a physician/clinician engagement strategy and tools to support health systems in advancing clinicians and ACOs in the Quality Payment Program (QPP) 5. Provide access to virtual education sessions within the IA HIIN and IA TCPI programs for clinic providers not enrolled in the programs 6. Deploy subject matter expertise and faculty to support development of alignment and engagement strategies, supporting best practice implementation and quality improvement techniques using HIT tools available. 7. Develop and implement local sampling techniques to measure community influenza vaccination rates and diabetes at goal 8. Conduct clinic and community workgroup sessions to align the Medication Effectiveness and Safety Statewide Strategy Plan and existing hospital adverse drug events (ADE) data to optimize processes for detection and prevention of Hospital Acquired Conditions (HAC) due to high harm medications.	05/31/17-04/30/18	IHC IHC IHC IHC IHC IHC IHC IHC

SIM Activity: SWAN Development to Improve Care Transitions			
Milestone/Measure of Success	**Action Steps**	**Timelin e**	**Responsible Parties**
Connect 45 Additional Hospitals to SWAN	1. Develop a plan with Iowa Health+ to determine hospitals in their clinics areas and how to start receiving ADT's for those hospitals 2. Determine departments within IDPH that have established relationships/work flows with hospitals and how we can incorporate SWAN into a requirement 3. Webinars for those hospitals not sending ADT's.	09/01/17	IDPH IDPH
Receive an eligibility file from all 5 Medicaid ACO's	1. The 3 MCO's to send Medicaid rosters to the 5 ACO's on a consistent basis 2. The 3 MCO's to set up VBP contracts with the 5 ACO's	06/01/2017	IME/IHIN
Receive an eligibility file from all 3 MCO's	1. MCO's and IME approval to send eligibility files 2. Set up kick off call to discuss eligibility file layout and next steps for setting up SFTP site with all 2 MCO's	05/01/17	IME/IHIN
Provide Technical assistance to a minimum of 2 ACO's/MCO's to ensure alerts are being used and are beneficial	1. Schedule follow up with MCO/ACO's who are receiving alerts to discuss usage 2. Develop a best practices document to share as the SWAN is expanded	09/01/17	IHIN/ICA
Receive eligibility file for Medicare patients from at least 1 of ACO's	1. Communicate with the 3 eligible Medicaid ACO's who also have a Medicare ACO that they can submit an eligibility file for the Medicare population 2. Start alerting on one of the ACO's Medicare patients	05/01/17	IHIN
Survey	1. Develop a survey to be sent to participating ACO's/MCO's who are receiving alerts 2. Survey sent to participants 3. Survey complete and results sent to IME	10/31/17	IHIN

SIM Activity: Standardize HRA Utilization and Use for SDH Measurement			
Milestone	**Actions**	**Timeline**	**Responsible Parties**
Increase use of social determinants and HRA outcomes data			
Deploy AMH as NCQA Certified Health Risk Screening Tool	1. 3M will receive NCQA approval of AssessMyHealth 2. Promote the use of AMH by MCOs 3. Create a process with 3M to modify the AssessMyHealth tool, accept submissions from new sources, and identify reporting procedures. 4. SIM team members will develop an issue brief or white paper demonstrating outcomes related to broad implementation of an HRA	06/30/17	3M, IME
Identify SDH questions for approval by Leadership team, stakeholders, and partners and add them to the tool or recommend their use within other tools.	1. IDPH will assist IME with identifying questions not included in AMH or MCO Risk Assessments 2. This list will be shared with governance structures and other SIM partners for approval 3. HRA tools including AMH will be updated with the identified questions	09/30/17	IME
Discuss use of AMH with Wellmark and with the Healthiest State Initiative to begin utilization of a HRA by the general population.	1. Meetings with key leadership of these organizations will be facilitated to provide information and to discuss the feasibility of incorporation of AMH into other venues and clinical practices	01/30/17	IME
Preparing to link HRA use to VBP			
Train SIM TA providers to assist providers to incorporate AMH into clinic and patient workflows	1. Best practices in incorporating the use of an HRA into clinic workflows will be utilized to train providers	11/01/17-ongoing	IHC, 3M, IDPH, IME
Train SIM TA providers to assist providers to incorporate the HRA and utilize the individual and aggregate reports.	1. Results of the aggregated reports will be shared with key partners, providers, health systems, Local Boards of Health, and other partners identified by the SIM team 2. Providers will receive technical assistance in utilizing aggregated as well as individual data	11/01/17 - ongoing	IHC, 3M, IDPH, IME
Incorporate use of AMH tool or SDH questions into MCO screening tools, to include utilization and data work plans	1. IME and Managed Care stakeholders will develop contract language to support the use of an HRA for MCO members 2. Outcomes will be jointly monitored	05/31/18	IME

State Population Health Work Plan. See Appendix D, HIT Work Plan, and Appendix E, Population Health Roadmap for more information			
Milestone	**Actions**	**Timeline**	**Responsible Parties**
System Care Coordination and Management: Meet with a minimum of three stakeholder groups to facilitate and advance local population health activities.	1. Connect C3s with IDPH subject matter experts in diabetes, tobacco prevention and control, and nutrition and physical activity 2. Develop referral system for C3 communities to access Iowa Healthiest State Initiative technical assistance for community-wide prevention activities that support the local SIM activities 3. Meet with MCOs regarding coverage of DSME and NDPPs in Iowa. 4. Routinely update IDPH programs, other state agencies, and state collaborative partners regarding SDH, diabetes, obesity and tobacco activities occurring with SIM.	1. Ongoing 2. 08/31/17 3. 03/30/18 4. Ongoing	1. IDPH and IHC 2. IDPH 3. IDPH and IME 4. IDPH
System Care Coordination and Management: Implement a Health IT workgroup to identify and report clinical quality measures.	1. Facilitate the Quality Measurement Identification and Collections HIT workgroup 2. Inform Health IT workgroup of diabetes-related SIM population health measures 3. Identify quality core metrics and reporting infrastructure	1. Ongoing 2. 01/31/18 3. 04/30/18	1. IDPH 2. IDPH 3. IDPH
Evidence-based Care and Patient Self-Management and Support: Support the local infrastructure for DSME and NDPP	1. Monitor # of NDPP and DSME programs, # of individuals completing the programs, and aggregated NQF measures in C3 regions. 2. Partner with the IDPH CDC 1305 and the Iowa Chapter of the American Diabetes Association to inform and educate C3 regions on upcoming trainings, resources, standards of care. 3. Identify gaps in NDPP availability in C3 regions and partner with the IDPH CDC 1305 Program to provide guidelines and technical assistance to implement new programs.	1. 04/30/18 2. Ongoing 3. 12/31/17	1. IDPH and IHC 2. IDPH 3. IDPH
Evidence-based Care and Patient Self-Management and Support: Update and promote the use of statewide strategy plans	1. Update statewide strategy plans and distribute/promote to local communities and state collaborative partners. 2. Provide statewide strategy plan tactics to 10 counties that have identified diabetes in health improvement plans; integrating in annual CHNA & HIP updates where possible.	1. Ongoing 2. 04/30/18	1. IDPH and IHC 2. IDPH
Linkages to Community-Based Resources to Address Patients' Social Needs: Develop success story or best practice document on SDH identification and referral process to inform non-C3 regions of C3 interventions	1. Incorporate SIM core metrics and AssessMyHealth data in the State Health Improvement Plan (Healthy Iowans) where possible 2. Identify commonalities of local referral systems and the Health IT systems used to support them	1. 04/30/18 2. 04/30/18	1. IDPH 2. IDPH

Section D: Evaluation and Program Monitoring

Ongoing Evaluation is the transparency and accountability that any lasting change needs. Evaluation lends the opportunity for continuous quality improvement for the health of the project. In addition to collaboration with the federal evaluation, Iowa has established a rigorous evaluation plan. There are two parts to this evaluation: 1) an assessment of the implementation/impact and process of the SIM interventions (intermediate outcomes) and 2) an assessment of the core SIM goals (primary outcomes) on three levels; a statewide evaluation of improvement, a community level evaluation of improvement, and a community level evaluation of process changes. The SIM core metrics reported quarterly and annually to CMMI can be found in Appendix B of this document.

1. State Led Evaluation

a. Plans for Award Year 3

As noted previously, the two-part evaluation will 1) assess the implementation/process of the key SIM interventions and 2) assess the core SIM goals and/or aims (primary outcomes used to measure the success of the SIM). The implementation studies evaluate the main SIM structural components intended to affect the goals.

b. Implementation/Process Evaluation for Award Year 3

The objective of the implementation/process evaluation is to describe the structure of the interventions/actions being utilized in the SIM model and the characteristics of the communities and settings which are impacted by the SIM. To do this, we will gather both qualitative and quantitative data from stakeholders, providers, consumers, and health systems to evaluate how the SIM model is being used, who is using the interventions and to what degree, and the successes and challenges experienced by the populations most affected by the SIM strategies. In addition to providing the contextual structure of the SIM activities, we will also describes the environment surrounding the SIM in Iowa by compiling information on statewide activities taking place outside of the SIM prior to and during implementation that may also affect the primary outcomes.

The key research questions for this part of the evaluation and a brief summary of the methods to address them follows.

1. How are the SIM interventions being implemented around the state of Iowa? To what extent are each of the SIM interventions being implemented consistently and what is the level of diffusion?

   Methods

   - Participate in bi-weekly phone conferences to receive status updates
   - Gather documents and information from SIM team
   - Review websites for updates

2. What non-SIM factors or statewide programs are in place that could also impact the SIM-specific goals?

   Methods
   - Focus on C3 and control counties
   - Search state websites and other documentation for concurrent healthcare initiatives

3. How effective has the implementation of SIM been? Level of use by impacted groups?

   Methods
   - Stakeholder Interviews
   - Provider Interviews
   - Patient/Consumer Surveys

4. What system, practice, and consumer level factors may contribute to SIM outcomes? Changes within the health care system in Iowa through SIM are widespread and variant; however, we will attempt to describe which intervention may have contributed to the meeting of aim or goal.

Based on the 2017 SIM Operational Plan, the primary SIM interventions proposed to further the SIM goals are quite similar to those proposed in 2016. In 2017, there may be additional activities or enhanced levels of already-in-progress activities that will be instituted by the SIM. Thus, the implementation evaluation will focus on the activities and proposed changes to the activities for the primary SIM interventions below.

- Roadmap to Improve Population Health (Diabetes Focus)
- Community and Clinical Care Initiative (C3)
- Statewide Alert Network (SWAN)
- Value-Based Purchasing (VBP) and work toward an Other Payer A-APM
- Technical Assistance (TA) for C3s and Healthcare Systems

Implementation / Process & SIM Evaluation Milestones for NCE & AY3
(January 1, 2017 – April 30, 2018)

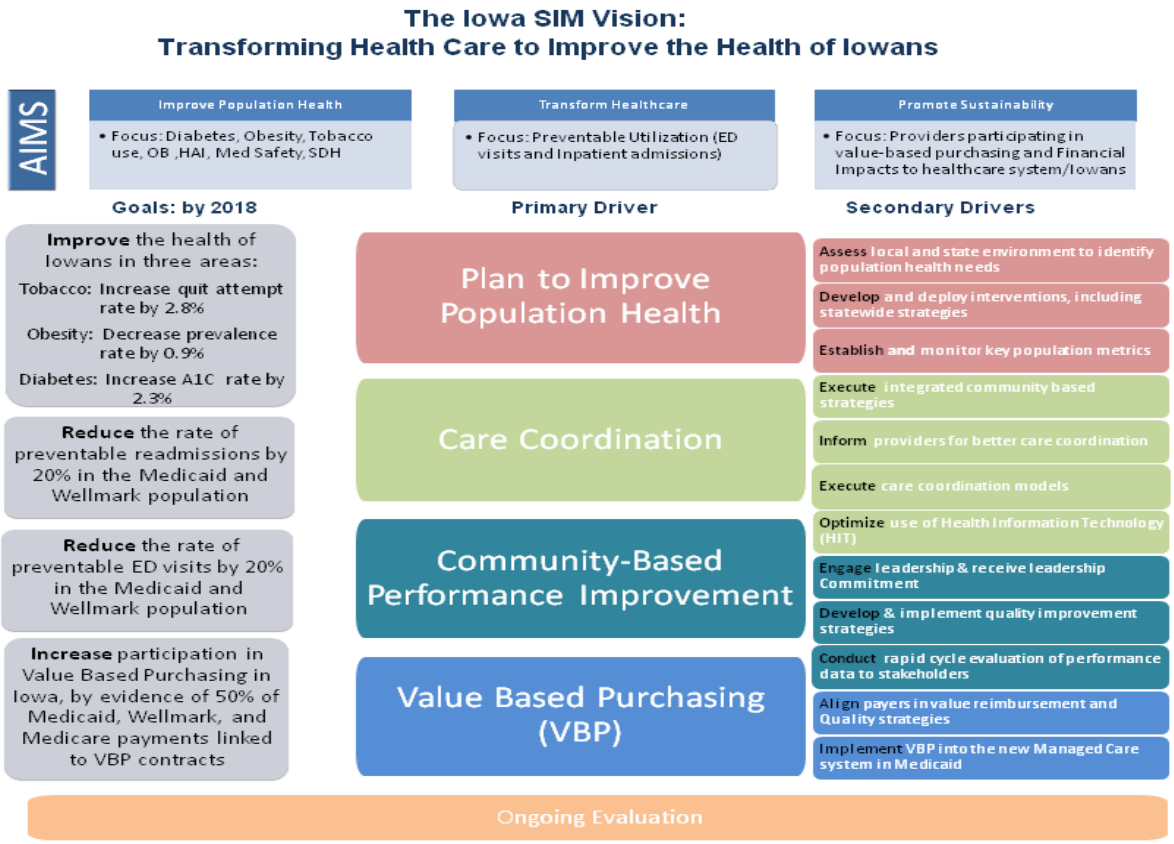
Figure 18: Evaluation Milestones

Milestone	Activity Timeline
Implementation/Process Evaluation Milestones: No Cost Extension	
Collect and organize document review information about SIM implementation in AY3	January 1, 2017 – December 1, 2017
C3 Clinic Manager, Provider, and Steering Committee Interviews	February 1, 2017 – May 1, 2017
Implementation/Process Evaluation Milestones: AY3	
Other SIM Provider and Stakeholder Interviews	May 1, 2017 – August 31, 2017
Statewide Consumer Survey Concludes Time in Field	February 28, 2017
Analyze Statewide Consumer Survey Data	March 15, 2017 – May 31, 2017
Evaluation Report on AY2 SIM Activities	October 31, 2017
Conduct Interviews of C3 Project Staff	September 1, 2017 – September 30, 2017
Conduct Interviews of C3 Participants (Consumer)	September 1, 2017 – November 30, 2017
Compile and Analyze Data for Report on AY3 SIM Implementation Activities	December 1, 2017 – April 30, 2018
Evaluation Report on AY3 SIM Activities	October 31, 2018
SIM Goal Evaluation Milestones AY3	
Complete data acquisition	June 30, 2017
SIM Goal Evaluation Report Part I Baseline CY 2015	October 31, 2017
SIM Goal Evaluation Report Part II Baseline CY 2015	April 30, 2018

c. Updates from Award Year 2

For Award Year 2, the evaluation by the University of Iowa's Public Policy Center (PPC) was based on the Vision document pictured below. In December 2016, the evaluators released their Baseline Implementation Report of Iowa's SIM activities (see Appendix G), outcomes related to these activities, and progress toward the identified goals from pre-implementation through the first three quarters of Award Year 2. The results included progress, challenges, and future considerations for all of the five main SIM activities within the Primary Drivers. Those activities were: Plan for Population Health Improvement, Community Care Coalitions, Statewide Alert Network, Community Based Performance Improvement, and Value Based Purchasing. The following updates are taken directly from the Baseline Report.

Figure 19: AY2 Driver Diagram



Two key evaluation questions were addressed by the PPC in this baseline report. They were:

1. How are the SIM interventions being implemented around the state of Iowa? To what extent are each of the SIM interventions being implemented consistently and what is the level of diffusion?
2. What non-SIM factors or statewide programs are in place that could also impact the SIM-specific goals?

While this is not a complete list of the process evaluation questions posed for the project, these were the most appropriate to address during this time frame. Future reports will include a more detailed exploration of SIM implementation and associated outcomes. As previously noted, the analysis included both qualitative and quantitative methods and multiple data sources to produce a comprehensive baseline report. An excerpt of the Executive Summary of the University of Iowa's Baseline Report is below:

Plan for Population Health Improvement (PHI)

Progress

- Developed and published seven statewide strategy plans to help guide population health initiatives and for use in SIM Technical Assistance (TA) educational and training activities.

Challenges

- Up to this point, efforts to disseminate the Statewide Strategy Plans have been passive and have included posting them to a website and including them in some TA activities. Year 1 was a development year for the Statewide Strategy Plans and, as such, C3 communities were not required to use or follow them. The use of the plans will need to be more actively encouraged among the SIM stakeholders if they are to have an effect on SIM goals regarding PHI.

Future considerations

- Given the potential changes in the design and focus of the Community Care Coalition (C3) initiative, it will be essential to continue to promote the importance of population health and social determinants of health as integral factors to be included within delivery system transformation and payment reform efforts if they are to meet the SIM goals regarding PHI.

Community Care Coalitions (C3s)

Progress

- Selected and funded three developmental and three implementation C3s across the state to promote care coordination across the healthcare delivery spectrum (medical, public health, and social service sectors) focused on supporting the SIM population health improvement areas of diabetes, obesity, and tobacco cessation.
- C3s have had individual successes building the local partnerships and coalitions necessary to carry out their SIM-specific as well as locally relevant population health and care coordination goals.
- All C3s have participated in SIM events and activities and have joined the SIMplify website.

Challenges

- C3s reported challenges in communicating with the Iowa Healthcare Collaborative (IHC), the Iowa Department of Public Health (IDPH), and other C3s during the first year of activity. Specifically five of the six C3 communities reported communication issues involving SIM staff including lack of responsiveness or follow-through, duplicative reporting requirements, and requests for more input into TA topics and resources.
- C3 communities wanted more opportunities to share best practices with each other during the initial implementation.

Future considerations

- C3 communities have made programmatic and systemic changes including, in some cases, the hiring of additional staff to work toward their objectives and fulfill their responsibilities as SIM grant sub-awardees. Given the impending changes to the C3 initiatives being contemplated for the coming years, the challenge will be to continue to support their progress and maintain the positive connections with the C3 communities while instituting potentially different criteria and goals into their operations.

Statewide Alert Network (SWAN)

Progress

- The SIM team was making progress in increasing the number of hospitals sending Admission, Discharge, and Transfer files (ADTs) to the SWAN Smart Alert Engine before having to cease operations because of a data sharing issue.
- All five of Iowa's Medicaid Accountable Care Organizations (ACOs) went "live" with the SWAN and were able to receive alerts.
- Technical assistance was instituted to identify and disseminate best practices for using the SWAN with at least one ACO (Broadlawns) actively using the SWAN information to enhance their care processes.

Challenges

- The SWAN initiative faced a significant challenge when the data sharing was curtailed. During the summer of 2016, it was brought to the attention of SIM staff that the ACOs maybe receiving alerts for Medicaid patients not attributed to that ACO which may have been a violation of the Health Insurance Portability and Accountability Act (HIPAA). In September 2016, all SWAN activity was halted as the SIM team worked with the State of Iowa Attorney General's office to resolve this serious issue.
- Initially, the Smart Alert system received Medicaid patient files from IME but with the advent of the Managed Care Organizations (MCOs) in April 2016, it became clear that the files from IME may not have the most current attribution. As of this report, the SIM initiative has been 5 actively working with all Medicaid ACOs and MCOs to generate and use their own eligibility files for the SWAN to ensure accurate attribution of patients.
- Mechanisms for using the SWAN alerts vary across the ACOs with little understanding of best practices or the opportunity to share them.
- When the SWAN system is active, the actual individual provider-level utilization of the SWAN is unknown with limited evidence of its integration into care coordination efforts at the system level.

Future considerations

- To sustain this effort beyond Medicaid, the SWAN will need to expand to other provider and health system networks such as those that participate in Wellmark and Medicare ACOs and determine ways for these additional entities to share eligibility files with the Smart Alert Engine.
- The ultimate goal is to have all hospitals sending ADTs to SWAN and the SIM initiative made progress throughout 2016 expanding those numbers. However, after SWAN activity was halted, momentum towards obtaining more hospital agreements was lost and it will be important to continue to promote the SWAN and grow the hospital network.
- Progress was made to get all five Medicaid ACOs to go "live" by receiving alerts from the SWAN. The SIM initiative will need to continue efforts to promote the use of the information they receive and ensure the alerts are useful. In addition, to have broader impact in the state, the SIM initiative should consider expanding these efforts to other health systems and providers.

Community Based Performance Improvement (CBPI)

Progress

- Implemented a multi-pronged, multi-modal technical assistance approach to inform, educate, and train the C3 communities.
- Developed and began to use multiple data-based technologies to help the C3 communities engage in quality improvement activities and performance evaluation.

Challenges

- Based on information from the C3 site visit interviews, the Learning Community events did not meet the needs of the C3s. The focus on broad concepts and state-wide implementation was not helpful, rather more emphasis on best practices and local successes were wanted.
- There were significant delays in the implementation of Rapid Cycle Performance Improvement (RCPI) activities.

Future considerations

- Gathering feedback from recipients of the TA to make these efforts more relevant to the individual C3s and incorporating that feedback into future programming will help to provide the most pertinent and timely assistance to the C3 communities.
- With the potential for significant changes to the design of C3 initiatives, it will be important to provide transparent, timely, and meaningful communication to the C3 partners about the changes to ensure that partnerships are maintained going forward.
- Maintaining progress with accurate data collection and analysis for RCPI and Quality Improvement (QI) activities will need to continue to be a focus. Value Based Purchasing (VBP) Progress
- A little less than one-half of Medicaid providers and a little over one-half of Wellmark providers are participating in some form of VBP using the Value Index Score (VIS).
- Have made progress with engaging the Medicaid MCOs in implementing VBP through contact requirements and encouraging the use of VIS.

Challenges

- For Medicaid, there was a shift from considering VBP arrangements with ACOs to the MCOs when Medicaid moved to Medicaid modernization and contracted exclusively with the three MCOs.

Future considerations

- Due to the introduction of state-wide managed care coverage for the Medicaid population and a directional shift to address the Medicare Access and CHIP Reauthorization Act (MACRA), increasing the proportion of provider and members in VBP contracts, especially those outside of the ACOs, will be challenging during the coming years.

Overarching Implementation Challenges SIM implementation progress came about during a period of significant change within the healthcare delivery landscape in the state of Iowa and a

federal legislative change to payment reform strategies that caused timeline delays and some re-prioritization of objectives. There were two specific challenges to SIM implementation that took place during this reporting period. The first, just two months after Iowa's SIM Test award had been publicized, the State announced the intention to move almost all of the Medicaid population into a privately run managed care delivery system. This massive shift in the administration of Medicaid and the management of its beneficiary population was to occur in less than one year. By January 1, 2016, almost all Medicaid populations were to shift to one of three managed care organizations (MCOs) chosen to manage Medicaid. This change had immediate implications for the SIM initiative and a great deal of time was spent reconciling the SIM plans under this new reality. Ultimately, Medicaid managed care of all populations was delayed until April 1, 2016 which presented additional challenges and alterations to SIM processes and implementation.

The second challenge came somewhat later in Year 1 (2016) in response to changes in federal legislation regarding payment. In 2015, legislation called the Medicare Access and CHIP Reauthorization Act (MACRA) was enacted in part, to repeal the Medicare sustainable growth rate (SGR) formula and institute changes to the way physicians are paid by Medicare. These changes to payment methodologies included a merit-based incentive payment system (MIPS) and created direct incentives to participate in Alternative Payment Methodologies (APMs). The MACRA legislation also created the potential for entities to engage in advanced APMs which are high risk/high reward payment methodologies that require Patient Centered Medical Homes (PCMHs). The MACRA legislation removed the SGR and replaced it with value based payment methodologies that link Medicare payments to provider performance. Rules for MACRA implementation were being decided over the summer of 2016 with the final rules scheduled to be published in November 2016. On the surface, this 7 change seemed to be in line with the SIM VBP strategies. However, discussions between CMMI and the SIM leadership led to the decision for the state of Iowa SIM to investigate strategies that more closely align with MACRA, which may lead some Iowa VBP programs to become an advanced APM as defined by MACRA. Thus, during the third quarter of Year 2 (2016), the Iowa SIM team has been working to transform the SIM initiative in Iowa to account for this shift in strategy. To that end, Iowa requested and was granted a no-cost extension of its Year 2 activities to have the time to develop its 2017 operational plan to incorporate these design changes.

d. Current research questions

The key research questions to be addressed in the statewide evaluation include:

1. How are the SIM interventions being implemented around the state of Iowa? To what extent are each of the SIM interventions being implemented consistently and what is the level of diffusion?

2. What non-SIM factors or statewide programs are in place that could also impact the SIM-specific goals?

3. How effective has the implementation of SIM been? What is the level of awareness and use of SIM activities by impacted groups?

4. Does the SIM decrease the use of tobacco?

5. Does the SIM improve outcomes of care for people with obesity?
6. Do SIM efforts improve the care of people with diabetes?
7. Does the SIM improve obstetrics outcomes?
8. Does the SIM improve medication safety?
9. Does the SIM reduce the rate of preventable readmissions?
10. Does the SIM reduce the rate of preventable emergency visits?
11. Does the SIM increase the proportion of payments linked to value-based purchasing?
12. Does the SIM decrease the total cost of care?
13. What system, practice, and consumer level factors may contribute to SIM outcomes? Changes within the health care system in Iowa through SIM are widespread and variant; however, we will attempt to describe when an intervention may have contributed to the meeting of a goal.

e. Implementation Evaluation Data Sources and Proposed Measures

The following table provides a summary of the methods, level of evaluation, data sources, and measures we propose to use to evaluate each main SIM intervention/activity.

Figure 20: Summary of Evaluation Components

SIM Intervention	Level of Evaluation	Data Sources	Measures Proposed
Population Health	Local (C3) & Statewide	• Document Review • Provider Surveys/Interviews • Stakeholder Interviews • BRFSS	• Number of counties with social determinants as goals • Awareness of Statewide Strategies • Use of Statewide Strategies • Others TBD
C3	Local	• Document Review • Stakeholder Interviews • Statewide Consumer survey • Local Patient Experience Survey • Provider Surveys/Interviews • BRFSS	• Composition of C3s • Awareness of C3 plans • Attendance at TAs • Changes in BMI • Changes in tobacco use • Diabetes rates • Others TBD
SWAN	Statewide	• Provider Surveys/Interviews • SWAN-specific data, if possible • Claims, if possible	• Location of SWANs • Number of alerts • Awareness of SWAN • Utilization of SWAN
VBP	Statewide	• Provider Surveys/Interviews • Medicaid provider data • Wellmark provider data	• Awareness of VBP • Awareness & use of VIS • Location of VBP providers
TA	Local (C3) & Healthcare System	• Document Review • Stakeholder Interviews • Provider Surveys/Interviews	• Hours & Personnel • Attendance at TAs • Requests for TA • Topics of TA

f. Evaluation of Award Year 3 SIM Goals

Primary goals of the SIM include a) improving population health, b) transforming health care, and c) promoting sustainability. The following research questions are addressed through the state-led evaluation. We have removed one area of investigation from the previous evaluation plan related to the quality of life for people diagnosed with obesity. No additional questions or methods have been added to the evaluation plan for the third year.

1. Does the SIM decrease the use of tobacco?

   Measure - Proportion of people who have made a quit attempt.
   Data sources:
   - BRFSS and YRBS data
   - Quitline data
   - Claims data

Measure – Rate of tobacco use.
Data sources:

- BRFSS and YRBS data

2. Does the SIM improve outcomes of care for people with obesity?

   Measure – Prevalence of obesity in adults.
   Data sources:
   - BRFSS data

3. Do SIM efforts improve the care of people with diabetes?

   Measure - The percent of adults diagnosed with Diabetes with 2 or more Hemoglobin A1c tests in the last year.
   Data sources:
   - Claims data

   Measure – The state wide diabetes rate will decrease.
   Data sources
   - BRFSS data:

   Measure - Hospitalizations related to the long-term and short-term complications of diabetes.
   Data sources:
   - IHA hospital inpatient data.

   Measure - ER visits for diabetes related issues.
   Data sources:
   - IHA hospital inpatient and outpatient data.

   Measure - Providers will integrate the statewide strategies for the care of diabetes.
   Data sources:
   - Provider survey.

4. Do SIM efforts improve the quality of life for people with diabetes?

   Measure – Quality of life measures.
   Data sources:
   - Survey data

5. Does the SIM improve medication safety?

   Measure – Rate of Glucose monitoring.
   Data sources:
   - Claims data

Measure – Rate of anti-coagulation monitoring.
Data sources:

- Claims data

6. Does the SIM reduce the rate of preventable readmissions?

   Measure – Rate of preventable readmissions.
   Data sources:
   - IHA inpatient data
   - Claims data

7. Does the SIM reduce the rate of preventable emergency visits?

   Measure – Rate of preventable emergency visits.
   Data sources:
   - IHA inpatient data
   - Claims data

8. Does the SIM increase the proportion of payments linked to value-based purchasing?

   Measure – Proportion of claims tied to VBP.
   Data sources:
   - Claims data

9. Does the SIM decrease the total cost of care?

   Measure: Adjusted Total Cost of Care.
   Data sources:
   - Claims data

SIM Goals Evaluation Data Sources and Proposed Measures for Award Year 3

Figure 21: SIM Evaluation Hypothesis List

Hypothesis	Measure	Data Source	State-established Outcome Targets	Outcome report date
Improve Population Health—Tobacco				
There will be an increase in the proportion of people interested in reducing tobacco use.	Number of people requesting information from the Quitline	Iowa Quitline data and claims data	2016: Increase 1.5% 2017: Increase 3.3% 2018: Increase 5.1%	10/31/2017 and 10/31/2018
The rate of tobacco use will decrease by 1 percentile over the 3 years of the SIM.	Rate of reported tobacco use (cigarettes)	BRFSS/ YRBS		10/31/2017 and 10/31/2018
Improve Population Health—Obesity				
Decrease adult obesity prevalence rates.	Weight and height measure	BRFSS/ YRBS	2016: Decrease 1.0% 2017: Decrease 1.9% 2018:Decrease 2.9%	10/31/2017 and 10/31/2018
Improve Population Health—Diabetes				
Increase the percentage of adults (aged 18 years or older) with diabetes having two or more A1c tests in the last year.	Hemoglobin A1c rates	Medicaid/ Wellmark claims data	2016: Increase 1.2% 2017: Increase 2.9% 2018: Increase 4.1%	10/31/2017 and 10/31/2018
The statewide diabetes rate will be reduced by 0.2 percentiles over the three years of the SIM.	Statewide diabetes rate	BRFSS		4/30/2019
The hospitalizations related to the long-term and short-term complications of diabetes will be reduced.	Admissions due to long-term and short term complication from diabetes	IHA inpatient file		4/30/2018
ER visits for diabetes related issues will be reduced.	ED visits due to long-term and short term complication from diabetes	IHA outpatient file		1/1/2018
Providers will integrate the statewide strategies for the care of diabetes.	Number of providers who integrate statewide strategies	Provider survey		1/1/2018

People with diabetes will experience improved quality of life (QOL).	Patient quality of life questions (to be determined)	Statewide consumer survey		10/31/2018
Improve Population Health—Medication Safety				
Increase the percentage of adults (aged 18 years or older) with diabetes having two or more A1c tests in the last year to monitor glucose rates.	Hemoglobin A1c rates	Medicaid/ Wellmark claims data	2016: Increase 1.2% 2017: Increase 2.9% 2018: Increase 4.1%	10/31/2017 and 10/31/2018
Monitoring of anti-coagulation medications will increase.	Hemoglobin A1c rates	Medicaid/ Wellmark claims data	2016: Increase 1.2% 2017: Increase 2.9% 2018: Increase 4.1%	10/31/2017 and 10/31/2018
Transform Health Care–Preventable Readmissions				
The SIM will reduce the annual rate of preventable readmissions by the third year.	Avoidable readmissions at 7days and 30 days (HEDIS)	IHA inpatient data	2016: Decrease 5% 2017: Decrease 15% 2018: Decrease 20%	10/31/2017 and 10/31/2018
Transform Health Care–Preventable ED visits				
The SIM will reduce the annual rate of preventable emergency department visits by the third year.	Rate of preventable ED visits as defined by NYC Billings algorithm	IHA outpatient file	2016: Decrease 5% 2017: Decrease 15% 2018: Decrease 20%	10/31/2017 and 10/31/2018
Promote Sustainability—Value Based Purchasing				
The proportion of provider payments linked to value-based purchasing contracts will increase to 50% by the third year.	Proportion of payments to Medicaid providers in VBP contracts	Medicaid provider dataset	2016: 25% 2017: 40% 2018: 50%	4/30/2019
The total cost of care per member will be reduced below the national average by the third year.	Cost of care per person in Iowa	3rd party vendor/ Medicaid/ Wellmark/ Medicare claims		4/30/2018 and 4/30/2019

2. Federal Evaluation, Data Collection, and Sharing

The collection and sharing of data is critical to the implementation, evaluation and sustainability of the SIM initiative. Awardees are required to cooperate with CMS and the CMS contractor's efforts to conduct the federal evaluation. The evaluation is independent, federally funded, and statutorily mandated in accordance with the requirements set forth in Section 1115A of the Social Security Act (added by Section 3021 of the Affordable Care Act) as part of the cooperative agreement. Awardees must include, as part of their operational plan,

documentation reflecting how they have addressed and will continue to address the following data collection and sharing requirements:

- Collecting, securing, and providing the necessary Medicaid data, private payer data and/or Medicare data (e.g. identifiers) in such a manner, including file specification, that CMS and its contractors can perform the federal evaluation.
  State Response: Metrics data was provided in CMMI template quarterly to provide a baseline. This information is available for Federal evaluators but was not sent to them directly.
- Providing data for all patients or individuals covered by the SIM program (public and commercial), including baseline and historical data for three years prior to the Project Period.
  State Response: Although the state evaluators had agreed to provide Medicaid data with the approval of the state if it was requested, the federal evaluators chose to use the Medicaid Analytic extract (MAX) data. Therefore, this data was not provided but the capacity to provide the data exists.
  State Response: Iowa has identified a C3 group versus statewide comparison group
- Providing CMS and its contractor(s) with identifying and contact information for beneficiaries who receive services under the model to examine patient care experience under this initiative.
  State Response: Files containing the focus group information were delivered through an SFTP for Urban Institute. We did not include Wellmark or Medicare clients in the focus groups.
- The state will coordinate and facilitate any sampling and data collection on behalf of CMS among, but not limited to, state payers, private sector payers, and health care providers
  State Response: The data has not been requested from the Federal evaluation team.
- Cooperating with primary data collection efforts such as, but not limited to, surveys, focus groups, and key informant interviews.
  State Response: This information is included in narrative below.
- Ensuring that the necessary legal mechanisms, authorities, and/or agreements are in place to ensure timely delivery of data to CMS and/or CMS contractors.
  State Response: This information is included in narrative below.
- Cooperating with the federal evaluation contractor and CMS for any other needs/requirements for the evaluation.
  State Response: This information is included in narrative below.
- Agreeing not to receive additional reimbursement for providing data or other reasonable information to CMS or another government entity or contractor.
  State Response: The State agrees to this condition.

The collection and sharing of data is critical to the implementation, evaluation and sustainability of the SIM initiative. Collaborating with our Federal Evaluators RTI and their subcontractor Urban Institute ramped up in mid-January when we began monthly meetings specifically to

organize efforts of our baseline federal evaluation of Iowa SIM. These meetings provided an opportunity to address the granular details needed to conduct an onsite evaluation which was conducted in May 2016 to establish baseline data. The evaluation consisted of conducting focus groups with providers, consumers and stakeholders. Agendas for these meetings included the appropriate identification and variables of focus groups and sharing the necessary data needed to compile these focus groups. Data sharing discussions began in January of 2016 with representatives from CMS's contractor RTI and Iowa's AAG Brad Horn to confirm the necessary documents were in place to follow HIPPA guidelines and protect client PHI. RTI shared their task order and the HIPPA compliance language in their IDIQ contract. This laid the groundwork for future data sharing for evaluation purposes in subsequent years. Language was also included in the C3 contracts to align with data sharing for evaluation purposes as well.

Our federal evaluators, as well as our state evaluators are also present on our CMMI bi-weekly calls to aid in their efforts to remain fluid in their evaluation and keep up with the iterations of our implementation activities. A copy of the Federal Evaluation plan was received and reviewed by our state evaluators to avoid potential overlaps in evaluation strategies.

Collaborating with our Federal Evaluators RTI and their subcontractor Urban Institute ramped up in mid-January when we began monthly meetings specifically to organize efforts of our baseline federal evaluation of Iowa SIM. These meetings provided an opportunity to address the granular details needed to conduct an onsite evaluation which was conducted in May 2016 to establish baseline data. The evaluation consisted of conducting focus groups with providers, consumers and stakeholders. Agendas for these meetings included the appropriate identification and variables of focus groups and sharing the necessary data needed to compile these focus groups. Data sharing discussions began in January of 2016 with representatives from CMS's contractor RTI and Iowa's AAG Brad Horn to confirm the necessary documents were in place to follow HIPPA guidelines and protect client PHI. RTI shared their task order and the HIPPA compliance language in their IDIQ contract. This laid the groundwork for future data sharing for evaluation purposes in subsequent years. Language was also included in the C3 contracts to align with data sharing for evaluation purposes as well.

The Federal Evaluation Team, RTI/ Urban Institute provided the following framework for inclusion in our Operational Plan for 2017:

1. **Next Steps**
   - I. Second round of qualitative data collection will be conducted weeks of March 6th and March 13th
   - II. Data collection will consist of 18-20 phone interviews with key informants
   - III. Statewide quantitative analysis using claims and survey data
   - IV. Potential for additional, model-specific quantitative analysis in future
2. **IA SIM Team Activities involving Federal Evaluation**
   1. Participation in monthly federal evaluation calls
   2. Providing suggestions and contact information for key informants
   3. Participating in in-person and phone interviews with the qualitative evaluation team

4. Assisted federal evaluation team in determining appropriate regions for focus groups and provided Medicaid data files for focus group recruitment

3. **Changes to Evaluation: N/A**

3. Program Monitoring and Reporting

The Iowa SIM initiative is largely implemented with contracts executed by the DHS. The oversights of those contracts are managed by the Contracts Management Office within IME in partnership with Telligen. The State has contracted specifically with Telligen to perform project management of SIM funded activities using a project management methodology to oversee the work streams of SIM activities within DHS and contractors. Staff from each contract meets regularly with SIM project managers to review milestones, action items, and risks. Items that need escalation are compiled and reviewed with IME/DHS/IDHP Leadership on a regular and as needed basis.

The SIM Project staff works closely with the implementation partners to identify risks associated with the SIM activities. Each identified risk is assessed based on the probability to occur and the impact on the project if it did occur. Risk identified with a high or medium probability and a corresponding high or medium impact are then sent into the mitigation planning process. Mitigation plans are identified to lessen or completely avoid negative impacts to the project. Action steps identified in a mitigation plan may be implemented immediately into the SIM master timeline or they may wait to implement based on factors that show the risk is starting to occur. These decisions are made at the SIM Implementation team level and reported quarterly to CMMI.

As described above, the State conducted risk identification, mitigation and monitoring during Award Year 2 and conducted a same review of current risks and identification of new risks which are identified in Appendix A. New risks are identified based on the work plans outlined and the experience to-date in implementing Iowa's Model Test.

Rapid Cycle Improvement is part of the regular contact with the SIM Innovation and Visioning Roundtable and the Strategic Implementation Teams. Data is shared at the various levels and strategic guidance is issued. See Figure 2: SIM Stakeholder Engagement and Governance Diagram.

Long term planning to sustain the monitoring and daily operation of SIM activities are in progress. Some activities will continue at the same level of oversight and project management. For example payer organizations like Medicaid and Wellmark are committed to sustain the resources necessary (oversight and analytic support) to carry out their value based payment programs. Other programs like SWAN are still developing sustainability plans. The non-profit organization responsible for the overall operations of the IHIN is currently identifying pricing models as SWAN transitions from a SIM funded to self-sustaining program. SIM is a model test and not all activities are expected to continue at the current SIM level. For example, technical assistance to the delivery system may look very different in a post SIM environment.

Further efforts to establish sustainability around programs and oversight of those programs is discussed in Section E.

4. Fraud and Abuse Prevention, Detection and Correction

The state is collecting quality data through a claims based submission process that falls under the guidance of our Program Integrity unit. Claims data are validated and audited to meet strict federal and state guidelines to prevent fraud and abuse.

Medicaid is implementing VBP strategies through our selected Managed Care programs. Managed Care programs are also validated and audited to meet strict federal and state guidelines and contractual requirements to prevent fraud and abuse.

Due to the method we are using, we feel there are no new exposures introduced for fraud and abuse that do not currently exist.

Medicaid contracts with a vendor to provide Program Integrity and Special Investigation Unity (SIU) oversight which includes running data analysis on prepaid and post-paid claims for potential fraud, waste, and abuse. If fraud, waste, or abuse is identified, the vendor conducts a desk audit or an on-sight audit as appropriate.

Section E: Sustainability

Iowa's State Innovation Model strategies have been designed to advance payment structures that promote high quality, cost-effective care, instigate critical conversations around population health, identify best practices in delivery system reform, develop collaborative relationships to support health improvement, and establish and build infrastructure for data sharing among partners that is both efficient and effective. Sustaining fundamental Delivery System and Payment Reform momentum beyond SIM funding can be addressed through the purposeful application of the information gathered and realizing the milestones identified in the operational plans for each award year. For example meeting the payment reform milestones identified will move Iowa closer to "critical mass" that allows for natural sustainability and momentum. However momentum takes effort and planning, and to sustain the vision, there is more to do in Iowa.

The state holds the philosophy that SIM is our current focus, but sustainability is related to continued transformation through efforts that ultimately supersede this project. A key factor will be the commitment of health and healthcare leaders to move toward and embrace changes that improve outcomes and quality of life across the population. Current plans are to secure a consultant to assist our Roundtable and Governance stakeholders to build a foundation that compliments and diffuses our successful innovations as well as distributing enthusiasm for change. Construction of this plan will create a new paradigm for health in Iowa.

The framework for planning will include examination of the following areas that reduce health care costs, improve quality, empower patients, and lead to increased health outcomes across the population:

1. **Environmental Support:** Building a stable internal and external climate for the work that provides a venue for supporting population health improvement activities.

2. **Financial Stability:** Assessment of the costs associated with both continuing the work and stopping the work and an exploration of the options available to Iowa for long-term funding.
3. **Partnerships**: Identifying the necessary collaboration among stakeholders that must continue to be sustainable and account for changes in personnel or administration in the future.
4. **Organizational Capacity:** Identifying effective management approaches for continued coordination and strategic planning for key SIM activities that promote the end state vision. Alignment with the Quality Payment Program (MACRA) and adaptability of payment and delivery models (including initiatives proposed under the Population Health Roadmap and expansion of health information technology and analytic infrastructure) in response to the changing health care market/landscape will provide a focus for this portion of the plan.
5. **Evaluation:** Build infrastructure for continued evaluation and adaptation of activities

An analysis of the work within each of the Primary Drivers reveals three categories of sustainability and corresponding effort to reach integration and normalization of SIM strategies. They are: Activities Requiring Facilitated Sustainability Planning, Easily Sustainable Activities, and Activities Requiring Further Support for Sustainability. Using these categories and the framework noted above, the leadership team will prioritize key strategies and promote sustainability of tactics throughout the Operational Plan.

There are four key innovations that will benefit from **Facilitated Sustainability Planning** and intensive stakeholder engagement. Innovations that will require financial support beyond SIM funding will garner immediate attention. Those innovations are:

- Gains in value-based purchasing and use of VIS
- SWAN utilization for care transitions
- HIT data analytics, interpretation, and utilization
- A commonly used Health Risk Assessment and the use of the subsequent individual- and population-level data

Much of our work will require further support beyond SIM to be sustained in the current state. This does not mean that the work will disappear, but that it will need attention from key stakeholders to become institutionalized. The work products in the category of **Activities Requiring Further Support for Sustainability** are:

Reorganization of the Delivery System:

- Success in APM
- Total Cost of Care reductions will depend on broadening the definition and role of delivery system ‘health’ to be maintained
- Reductions in preventable ED visits, Readmissions, and HACs through care coordination, use of HRAs, and recognition of and interventions in social determinants will require continued dialogue and formalized interventions. Until interventions for social determinants are normalized, and triggers for those interventions become

obvious, addressing patient's social needs will require further dialogue, support, and training, and stakeholders will need to agree on measures for assessment

Partnerships:

- Managed Care Organization engagement and support will be unstable until the organizations have established their models of practice in Iowa
- Other payer supports (Wellmark)
- ACH model and C3 structure: The successful pilots of these systems will spread slowly and will depend on strong relationships and supports among health and healthcare entities that originate at the State level.
- Shared vision of delivery system reform across sectors as initiatives change and new structures are introduced

Environmental Support:

- Technical Assistance: Funding dependent activities in Statewide Strategy Plans, Community Scorecard, SIM Portal, and Learning Events
- Roadmap activities will need modified and updated with continual cross-sector management and ownership of the plan
- Evidence-based care and patient self-management and support will be a moving target as models and initiatives change and new research becomes available
- Community engagement in prevention and intervention for specific conditions progress is slow and behavior change is difficult when the root causes of disease are challenged by environmental competition
- Workforce capacity: consistent education and training will need to be in place to make this sustainable. Iowa will embrace exploration of new staffing structures that support the success of delivery system models.

Evaluation:

- Evaluation: as Iowa embeds new initiatives or institutionalizes current initiatives, consistent evaluation is recommended to ensure a high-level of success across stakeholders as well as the ability to diffuse the innovations across the state

Some of the work within Iowa's SIM will be **Easily Sustainable**. These structures, when embedded over the span of the project, will become foundational and fully adopted due to their immediate successes that represent incremental change tolerated by stakeholders. Structures that have statewide supports will also be easily sustained by 2019. They are:

Reorganization of the Delivery System:

- Approval of an AAPM
- Improvements in quality measurement and data driven decision making
- Use of common language across sectors

- Quality measure alignment

Partnerships:

- Partnerships, collaboration, steering committees, and Governance/Roundtable structures

Environmental Support:

- Quality tied to payment (Value-based purchasing)
- HIT improvements and utilization
- Healthcare Transformation Initiatives: These will change, but Iowa has active interest from a wide variety of partners to institute these activities as the opportunities are available.
- Data sharing agreements and engagement (Raw claims/ Encounter data, etc.)

Bringing a consultant to the team to appropriately identify sustainable work we are already engaged in as well as logical next steps with a strategic implementation plan will ensure implementing our plan is meaningful and work from the SIM project can be assigned seamlessly prior to the end of the project. Iowa's SIM has the potential to be scalable and the work transferred to other partners and systems due to the motivation by payers, providers, state and local agencies, and leadership to normalize the innovations shared in our project summary and end state vision and carry them into Iowa's future. It should be noted, however, that the key to sustainability for change does not lie in any one project or activity. Iowa recognizes that the competition for quality within the delivery system and a consumer base that is informed and demanding of cost-effective, high-quality, efficient care, are powerful drivers not motivated by current initiatives. These ultimate drivers will require time to fully endorse what SIM proposes.

Appendices: Separate Documents

Appendix A – Risk Assessment & Mitigation

Appendix B – SIM Metrics AY3

Appendix C – Stakeholder Engagement & Communication

Appendix D – HIT Enhancement Planning

Appendix E – Roadmap to Improve Population Health

Appendix F – DRAFT Medicaid Quality Payment Program

Appendix G – SIM Baselines Implementation Report December 2016

Appendix H – Informal Outcomes of C3s (AY2)

Table of Figures

Glossary of Acronyms

Acronym	Represents
ACH	**Accountable Communities for Health model**
ACO	**Accountable Care Organizations**
ADE	**Adverse Drug Events**
ADT(s)	**Admissions, Discharges & Transfers**
AMH	**AssessMyHealth**
APM(s)	**Alternative Payment Models**
AAPM(s)	**Advance Alternative Payment Models**
BRFSS data	**Behavioral Risk Factor Surveillance System**
C3	**Community & Clinical Care**
CAP	**Corrective Action Plan**
CDC	**Center for Disease Control and Prevention**
CDSMP	**Chronic Disease Self-Management Program**
CEHRT	**Certified Electronic Health Record Technology**
CHIP	**Children's Health Insurance Program**
CHNA	**Community Health Needs Assessment**
CMMI	**Center for Medicare/Medicaid Innovations**
CMS	**Centers for Medicare and Medicaid Services**
COB	**Coordination of Benefits**
CQM(s)	**Clinical Quality measures**
DHS	**Department of Human Services**
DSME	**Diabetes Self-Management Education**

eCQMS	**Electronic Clinical Quality Measures**
ED	**Emergency Department**
FPL	**Federal Poverty Level**
FFS	**Fee for Services**
FOA	**Funding Opportunity Announcement**
HAC	**Hospital Acquired Conditions**
HEN	**Hospital Engagement Network**
HHS	**Health and Human Services**
HINN	**Hospital Improvement Innovation Network**
HIP	**Health Improvement Plan**
HIPAA	**Health Insurance Portability & Accountability Act**
HIT	**Health Information Technology**
HRA	**Health Risk Assessment**
IDPH	**Iowa Department of Public Health**
IHC	**Iowa Healthcare Collaborative**
IHIN	**Iowa Health Information Network**
IME	**Iowa Medicaid Enterprise**
IPOP	**Inpatient Outpatient**
IT	**Information Technology**
LBOH	**Local Boards of Health**
LTC	**Long Term Care**
LTSS	**Long Term Care Services and Supports**
MACRA	**Medicare Access and CHIP Reauthorization Act**
MBHO	**Managed Behavioral Health Organization**

MCO	**Managed Care Organization**
MIPS	**Merit-Based Incentive Program System**
MSSP	**Medicare Shared Savings Program**
NDPP	**National Diabetes Prevention Program**
NQF	**National Quality Forum**
ONC	**Office of the Nat'l Coordination for Health Information Technology**
OP – AAPM	**Other Payer Advanced Alternative Payment Model**
PCCM	**Primary Care Case Management**
PCP	**Primary Care Provider**
PDSA	**Plan DO Study Act**
PHI	**Personal Health Information**
PCMH	**Patient Centered Medical Home**
PMPM	**Per Member Per Month**
PPC	**Public Policy Center**
QI	**Quality Improvement**
QIO	**Quality Improvement Organization**
QIN	**Quality Improvement Network**
QPP	**Quality Payment Program**
RCPI	**Rapid Cycle Performance Improvement**
RFP	**Request for Proposal**
RTI	**Research Triangle Institute**
SDH	**Social Determinates of Health**
SFTP	**Secure File Transfer Protocol**
SIM	**State Innovation Model**

SWAN	**Statewide Alert Notification**
TA	**Technical Assistance**
TCI	**Total Cost Index**
TCOC	**Total Cost of Care**
TCPI	**Transforming Clinical Practice Initiative**
VBP	**Value Based Purchasing**
VIS	**Value Index Score**
YRBS data	**Youth Risk Behavior Surveillance System**