IDPH wanted **single line item** to Iowa PCA with no earmarks.

Governor proposed **status quo funding**.

Collaborative proposed **three line items** built around areas of identified need:

- **Access** (specialty care initiatives): $1,025,485
- **Engagement** (network & rural health clinics): $185,285
- **Integration** (community care teams): $1,672,199
Governor’s veto = 58% cut in funding!

### Challenges Ahead

- **Unknown Political Landscape.**
- **Long-Term Sustainability Plan.**
  - Proving ongoing need.
  - Duplication.
  - Identifying gaps & new strategies.
- **Direction for Collaborative in New Environment.**
  - Missing partners.
  - Competition.
  - Integration of new models.
Looking Ahead at 2016…

• **Veto Results:**
  What is the impact?

• **New Opportunities:**
  What gaps still exist?
  Strategies to mitigate?

• **Strategies for 2016:**
  Where do we go from here?

---

Revisiting Transition Planning Identified Priorities

IOWA COLLABORATIVE SAFETY NET PROVIDER NETWORK
SEPTEMBER 3, 2015
SN Legislative Language Background

- IDPH approached us regarding streamlining # of line items
  - From 10 to 1
- Discussions
  - Leadership Group – Jan. 6, Jan. 30, March 13
  - Leadership & Advisory Group – Jan. 16, April 10
- Middle Ground (3 line items)
  - Access, Integration, Engagement
  - Based Safety Net Strategic Plan Workgroups

Final Safety Net Legislative Funding Action

- Access - $1,025,485 – Passed
  - Iowa Prescription Drug Corporation - $413,415
  - Free Clinics and Free Clinics of Iowa - $348,322
  - Iowa Coalition Against Sexual Assault (SART) - $50,000
  - Polk County Medical Society (specialty health care) - $213,748
- Integration - $1,672,199 – Passed but Vetoed by Governor
  - Community care coordination team development, integration of medical and behavioral health services, supporting Medicaid Managed Care and SIM efforts
- Engagement - $185,285 – Passed
  - Iowa Association of Rural Health Clinics - $25,000
  - Iowa Primary Care Association - $160,285
  - Salary/fringe - $97,085
  - Other (SN meetings, website, etc.) - $32,700
  - Technical Assistance (Rural Health Solutions, other TA) - $30,500
Status Update

- Leadership group met August 5
- Contract with IDPH is imminent
- Proposals from 5 grantees received and MOAs prepared for execution
- Second, potential contract with IDPH
  - CCC support during transition, data definitions, tools development

Revisiting SN Transition Plan - Potential Activities

- Ongoing Needs of Uninsured
  - Gaps analysis
  - During Transition to Medicaid Modernization
  - Reconvene data workgroup (what data is needed & avail.)
- Outreach & Enrollment
- Integration & Engagement
  - Identify barriers to care
  - Transitions support
  - Host/facilitate specific training, webinars, forum
  - CCC SIM role TBD; i.e. incubation, barriers
- Seek Infrastructure Funding for SN Providers
Outreach & Enrollment

Training Opportunity - Outreach & Enrollment

➤ SN Providers doing more Outreach & Enrollment
➤ Get Covered Academy from Enroll America
➤ Scholarship opportunity made possible by Robert Wood Johnson
  • Application deadline is August 31
  • Services represent more than $25,000
➤ Exploring Other Funding Opportunities
Get Covered Academy from Enroll America

- Training and coaching services
  - Identifying uninsured consumers in your community
  - Developing effective follow-up programs that lead to concrete results
  - Increasing the effectiveness of in-reach
- Monthly webinars
- In-person training focused on Open Enrollment Period 3 (OE3)

Get Covered Academy from Enroll America

- Utilizing experience and expertise gained from 2 open enrollment periods
  - Opportunity to network with veteran assisters
- Embed best practices & most effective tools and tactics
  - Get Covered Connector
  - Get Covered Calculator
- Heavy focus on data capture & analysis
Connecting with Stakeholders

- Iowa Insurance Division previously held bi-weekly stakeholder calls during Open Enrollment
  - Funding will no longer continue
  - Approached by CMS Region VII office to host the calls
  - Updates from Iowa Medicaid Enterprise and CMS, opportunity for assisters to ask questions

- Iowa Health Insurance Marketplace Assister Summit hosted by CMS
  - Tuesday, September 29 from 9:00 a.m. to 4:15 p.m.
  - Wallace Building

Importance of O/E Discussions

- Navigating four separate companies for managed care will be challenging
- Getting people enrolled and helping them keep their coverage will be helpful to MCOs and the people we serve
- Two additional statewide plans joining Health Insurance Marketplace – will require consumers to be educated about new options
  - Medica
  - UnitedHealthcare
Iowa Safety Net Provider Network
September 3, 2015
Rochelle Schultz Spinarski
Rural Health Solutions

Evaluation Activities

› Reporting
  ◦ Monthly – Implementation CCCs (incl. tele-conf)
  ◦ Quarterly – All other
› Surveys – Implementation CCCs
  ◦ Patient Satisfaction
    ▪ Telephone
    ▪ UofIA
  ◦ Healthcare Providers
  ◦ Community Partners
› Interviews
  ◦ MJE
  ◦ Seasons
Community Care Coordination (CCC) Initiatives

- Cerro Gordo (aka Mercy)
- Webster County Public Health
- Methodist Jennie Edmundson (aka MJE)
- Dallas County Public Health
- Allen Memorial Hospital
- Seasons Center for Behavioral Health
- Des Moines YMCA Health Living Center
- Allen Memorial Hospital
- Allen Memorial Hospital
- Healthy Henry County Communities
- Shenandoah Medical Center

Implementation | Developmental | Exploratory

CCC – 3,664 People Served

Dallas County Public Health

- 793 Patients served
- Avg. 1.24 RF/Patient
- 1,331 Assistance Services
  - Insurance (31%), access to med care (19%), financial (14%)
  - 86% working age (20–69)
  - Even age distribution*
- Other
  - Hosted a social return on investment training
  - Navigation referral database
  - Facilitated system level changes
  - Established new relationships
  - Leveraging other funds
  - Plans to apply for future developmental or implementation grants

Developmental Grantees
Seasons Behavioral Health

- Clay and Sioux Counties
- Started as an implementation grantee
- Focus: Provide integrated behavioral health care by embedding behavioral health within a primary care setting
- Limited patient data reported
  - Case Studies: Correct intervention → lower level of care
  - Education: Medication and crisis management
- Other
  - Identified 4 main issues of patients: housing, transportation, medication, and insurance
  - Partnerships established, meetings held
  - Plans to apply for future developmental grant

Allen Memorial Hospital

- Black Hawk County
- Focus on depression and its link to chronic conditions
- No patients reported
- Other
  - Partnerships developed, meetings held
  - Plans for future development created
  - Position description for lead staff developed
  - Plans to apply for additional developmental grant
Implementation CCC Grantees

All Implementation CCCs: Population Served By Age

- 0 - 19 Years: 26%
- 20 - 39 Years: 25%
- 40 - 59 Years: 23%
- 60 - 79 Years: 14%
- 80 Years and Older: 8%
- Unknown: 4%

CCC – 2,871 People Served

Race and Ethnicity of Population Served

- White (not Hispanic): 54%
- Black or African American: 7%
- American Indian and Alaska Native: 2%
- Asian: 1%
- Hispanic: 17%
- Other: 7%

- 36 Veterans*
- 16% Employed*
- 77% White/Non-Hispanic

CCC – 2,871 People Served
Methodist Jennie Edmundson

- 3 County Region:
  - Pottawattamie
  - Mills
  - Cass
- Target Pop
  - High Risk Patients
- 857 Patients
- 1,362 Encounters Tracked
- 2,715 Referrals Made
  - 2225 Insurance Counseling
  - 331 Transitional Coach
  - 107 Health Coach

Population Served

Age

MJE

Chronic Conditions

Risk Factors
MJE

**Assistance Services Provided**

<table>
<thead>
<tr>
<th>Service</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transportation Services/Voucher placed</td>
<td>195</td>
</tr>
<tr>
<td>Patients received assistance with Medication</td>
<td>130</td>
</tr>
<tr>
<td>Patients received meds from IA Prescription Drug Program/DDRP</td>
<td>7</td>
</tr>
<tr>
<td>DME placed</td>
<td>84</td>
</tr>
<tr>
<td>Meal Assistance</td>
<td>60</td>
</tr>
<tr>
<td>Day-to-Day Expenses</td>
<td>5</td>
</tr>
<tr>
<td>House Modifications</td>
<td>2</td>
</tr>
</tbody>
</table>

**Outcomes**

- 50% Uninsured when enrolled, 546 obtained insurance
- Cholesterol
  - 1 improved, 254 reduced
- Blood Pressure Mgmt
  - 10 improved
- A1c
  - 2 patients, 1 improved

Webster County

**8 County Region**

**Target Pop:**

- Medicaid or uninsured
- Medically complex
- Multi-occurring behavioral health conditions
- Children
  - 1,339 Patients
  - 3,107 Encounters Tracked
  - 45% Under Age 5
Webster County

Age of Population

Medical Risk Factors

Webster County

Social Determinants of Health

Outcomes

<table>
<thead>
<tr>
<th>Social Determinants</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cholesterol management (&lt;200 mg/dL)</td>
<td>35% Improved</td>
</tr>
<tr>
<td>Blood pressure management (&lt;140/90)</td>
<td>50% Lowered BP</td>
</tr>
<tr>
<td>Smoking cessation (37)</td>
<td>81.5% Quit Rate</td>
</tr>
<tr>
<td>A1C (10.9)</td>
<td>82% Improved</td>
</tr>
<tr>
<td>Weight loss (400)</td>
<td>30% Lost Weight</td>
</tr>
</tbody>
</table>

15 Patient Sample – Savings
- ED – $27,950
- Hosp Admit – $112,000
Cerro Gordo

- 675 Patient (456/219)
- 4,882 Encounters Tracked
- Target Pop:
  - Uninsured
  - No established primary care provider
  - Diabetes and/or heart failure
  - Unable to afford their medications

Population Served | Age
---|---

Cerro Gordo

<table>
<thead>
<tr>
<th>Access to Care</th>
<th>123</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial</td>
<td>259</td>
</tr>
<tr>
<td>Functional</td>
<td>79</td>
</tr>
<tr>
<td>Health Literacy</td>
<td>64</td>
</tr>
<tr>
<td>Health Management</td>
<td>108</td>
</tr>
<tr>
<td>Housing</td>
<td>50</td>
</tr>
<tr>
<td>In-Home Care</td>
<td>34</td>
</tr>
<tr>
<td>Insurance</td>
<td>162</td>
</tr>
<tr>
<td>Language</td>
<td>7</td>
</tr>
<tr>
<td>Legal</td>
<td>19</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prescription</th>
<th>97</th>
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<tbody>
<tr>
<td>Psycho Social</td>
<td>113</td>
</tr>
<tr>
<td>Supplies</td>
<td>12</td>
</tr>
<tr>
<td>Support</td>
<td>21</td>
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<tr>
<td>Transportation</td>
<td>105</td>
</tr>
<tr>
<td>Work</td>
<td>48</td>
</tr>
<tr>
<td>Heart Disease</td>
<td>23 (11%)</td>
</tr>
<tr>
<td>Diabetes</td>
<td>45 (21%)</td>
</tr>
<tr>
<td>ED Visit w/in 45 days</td>
<td>8</td>
</tr>
</tbody>
</table>

Avg. 6.3 / Person
Cerro Gordo (enrolled)

<table>
<thead>
<tr>
<th>Types of Interventions</th>
<th>Assistance Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Gap Closed</td>
<td>391</td>
</tr>
<tr>
<td>Clinical Escalation</td>
<td>36</td>
</tr>
<tr>
<td>ED Deferred</td>
<td>5</td>
</tr>
<tr>
<td>Admission Deferred</td>
<td>5</td>
</tr>
<tr>
<td>New Physician Obtained</td>
<td>7</td>
</tr>
<tr>
<td>Utilized Community Resource</td>
<td>315</td>
</tr>
<tr>
<td>Access to Care</td>
<td>100</td>
</tr>
<tr>
<td>Financial</td>
<td>133</td>
</tr>
<tr>
<td>Functional</td>
<td>13</td>
</tr>
<tr>
<td>Health Literacy</td>
<td>2</td>
</tr>
<tr>
<td>Health Management</td>
<td>25</td>
</tr>
<tr>
<td>Housing</td>
<td>11</td>
</tr>
<tr>
<td>In-home Care</td>
<td>6</td>
</tr>
<tr>
<td>Insurance</td>
<td>54</td>
</tr>
<tr>
<td>Language</td>
<td>9</td>
</tr>
<tr>
<td>Legal</td>
<td>6</td>
</tr>
<tr>
<td>Prescription</td>
<td>40</td>
</tr>
<tr>
<td>Psycho-Social</td>
<td>10</td>
</tr>
<tr>
<td>Supplies</td>
<td>9</td>
</tr>
<tr>
<td>Support</td>
<td>1</td>
</tr>
<tr>
<td>Transportation</td>
<td>82</td>
</tr>
<tr>
<td>Work</td>
<td>3</td>
</tr>
</tbody>
</table>

Avg. 2.28/person

Patient engaged with Community Care Coordinator who obtained a Primary Care Provider and assisted patient to obtain necessary diabetic supplies, diabetic education and access to dental care.
Cerro Gordo

- 41 Uninsured, 34 Obtained insurance
- 9/13 decreased A1c
- 1/13 increased A1c
- Declines in ER utilization
- Declines in hospital admissions

Outcomes

- 79% Part of initiative
- 88% Aware of the role of the CCC
- 58% Report CCC accomplishing its goals
- 55% Receive referrals
  - PCPs receiving referrals are satisfied with the referral process
- 65% Make referrals
  - 58% Do not receive patient information when referrals made from the CCC
- 29% Involved in CCC planning
  - 41% Would like to be involved in CCC planning
- 35% Receive CCC program communications
- 81% Support ongoing development of CCC, 19% Unsure
- All but one report they plan to continue their involvement and referrals to CCC

“Unsure how successful it has been as this program seems to duplicate some services we already offer.” – CCC Provider

Healthcare Provider Perspective

“This definitely needs to be expanded to surrounding counties.” – CCC Provider

3 CCC Implementation Grantees
N=19, 53% Primary Care Physician, 63% part of system
(4 Cerro Gordo, 5 MJE, 10 Webster)
Community Partner Perspective

100% Aware of CCC goals
78% Accomplishing its goals
62% Receive referrals, 22% Unsure
   • 83% Satisfied with referral process
81% Make referrals
   • 97% Satisfied with referral process
67% Not involved in CCC planning
   • 50% Involved in steering committee meetings
   • 75% Would like to be involved in planning
70% Receive CCC communications/updates
   • 48% Monthly, 19% Once a year
   • 91% Satisfied
65% Integral part of local healthcare delivery system
88% Development, expansion, funding
82% Ongoing involvement

“This is a work in progress.” – CCC Partner

Survey
- 29 questions
- Telephone survey
- Topics:
  - How the participant heard about the program
  - Types of services they received referrals
  - Process for deciding which services were needed
  - Experiences with the process of obtaining their needed services including rating how well the communication worked among all of the parties involved in the referral

Patient Satisfaction

<table>
<thead>
<tr>
<th>Site</th>
<th>Adjusted* Number of Patients with Attempted Interviews</th>
<th>Interviewed (Participation Rate %)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cerro Gordo</td>
<td>77/</td>
<td>47 (60%)</td>
</tr>
<tr>
<td>Webster</td>
<td>4/</td>
<td>1/ (50%)</td>
</tr>
<tr>
<td>Jennie Edmundson</td>
<td>63/</td>
<td>15 (24%)</td>
</tr>
<tr>
<td>Total</td>
<td>207/</td>
<td>71 (35%)</td>
</tr>
</tbody>
</table>

CAUTION:
- 18% Cerro Gordo
- 1% Webster Patients
- 6% MJE
Findings
Patient Satisfaction Survey

Most of the feedback was +
- Appropriate identification and coordination of referrals
- Timely contact
- Referrals align with program goals
- Referrals for multiple services
  - Cerro Gordo
    - Expansion in referral sites
    - More likely received services 89%
  - Webster
    - Only 2 report ER instead of PC
    - More likely received services 81%
  - MJE
    - 78% ER follow-up

Themes

- Insurance changes – Patient, Insurer
- DEDICATED STAFF
  - Staff retention
  - Process improvement built into project operations
- Communications
  - Internal
  - External
  - Regular, multi-strategy
- Capacity, tools, and communications surrounding patient data and outcomes
  - Data sharing
  - Overlap between initiatives (what gets attributed to what?)
- Steering committee engagement
Questions?

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Rural Health Solutions
651-731-5211
rspinarski@rhsnow.com

Safety Net Advisory and Leadership Group
September 3, 2015
Today’s Agenda:

* Patient query approvals
* RFI results
* RFA status
* Current IHIN numbers and participants

New Patient Query Access

* Iowa Medicaid Enterprise
* Iowa Pharmacy Association
RFI

- RFI was issued in June
- There were 5 responses
  - Catholic Health Initiatives of Iowa (CHI)
  - KaMMCO Health Solutions Inc (KHS)
  - Nebraska Health Information Initiative INC (NeHII)
  - SIMI Group
  - University of California San Diego (UCSD)

RFA

- Plan is to issue in fall 2015
- Award in January 2016
- Complete transition by July 1, 2016
Current Query Participants

UnityPoint (Story County Medical Center, Community Memorial Hospital, Guthrie County Hospital, Stewart Memorial Community Hospital, Greater Regional Medical Center, Marengo Memorial Hospital, Greene County Medical Center, Buena Vista Regional Medical Center, Grundy County Memorial Hospital, Guttenberg Municipal Hospital, Pocahontas Community Hospital, Trinity Regional Medical Center, Trinity Moline, Trinity Rock Island, Trinity Muscatine, Trinity Bettendorf, St. Luke’s Sioux City, St. Luke’s Cedar Rapids, Methodist West Hospital, Jones Regional Medical Center, Iowa Methodist Medical Center, Iowa Lutheran Hospital, Finley Hospital, Allen Hospital, Continuing Care Hospital at St. Luke’s, Loring Hospital, Humboldt County Memorial Hospital, Clarke County Hospital & Cherokee Regional Medical Center, Blank Children’s Hospital & 275 clinics through Iowa and Illinois), Mary Greeley/McFarland, Gunderson/Palmer, Broadlawns, Trinity Health Michigan (Dubuque, Mason City, Clinton & Sioux City), Decatur, Dallas County, UIHC, Henry County, Jefferson County Health Center, Spurgeon Manor (query only do not contribute), Hillcrest Family Services, Genesis, Clarinda Regional Health Center, MercyCare Service Corporation, & Keokuk Hospital

Query Statistics

Number of Records Requested vs Number of Records Returned
Questions?

Thank You!

Sarah Brooks  
Privacy and Security Officer  
Iowa e-Health, IDPH

Tracy Donner  
Project Manager  
Iowa e-Health, IDPH

Iowa e-Health  
http://www.IowaeHealth.org  
866-924-4636  
ehealth@idph.iowa.gov
IDPH Office of Health Care Transformation Update

Angie Doyle Scar
Abby Less
9/3/15

Legislative Update

• Name Change Codified
  – “Patient-Centered Health Advisory Council”

• Funding now directly to the Office of Health Care Transformation

• Staffing Update
  – Direct Care Worker
  – New IPDH SIM Positions
Patient-Centered Health Advisory Council

- 3 Topic-Focused Meetings:
  - Workforce
  - Aging in Place
  - Behavioral health

- Meeting Schedule:
  - Wednesday, November 18 - Iowa Hospital Association
  - Friday, February 19th, 2016
  - Friday, May 20th, 2016
  - Friday, August 12th, 2016
  - Friday, November 4th, 2016

IDPH Affordable Care Act Impact Studies

- The studies focus on three areas: covered populations, covered benefits, and provider networks.
- 1st Study:
  - Overall demand for IDPH-funded substance abuse treatment is projected to initially decrease and then remain level through 2017, with IDPH responsible for a reduced percentage of outpatient treatment services and all residential treatment.
  - Demand for home care aide and nursing services will not change, primarily because the covered population is generally aged 65 and older, and therefore not eligible for ACA enrollment.
  - Demand for tobacco Quitline and tobacco-related cessation services is projected to increase as such services are not currently available in some new health plans.
  - Demand for cervical cancer screening and other preventative services is projected to decrease as historically eligible women become enrolled in new health plans.

- 2nd Study:
  - Title V Maternal and Child Health
  - Title X Family Planning
  - Ryan White Part B and Community-Based Screening Services
  - Oral Health Dental Sealant Program
Contact Information

• Angie Doyle Scar- 515-954-9537
   Angela.DoyleScar@idph.iowa.gov

• Abby Less- 515-321-4361 Abby.less@idph.iowa.gov

Three Keys to SIM in the Iowa RFP for Managed Care and Project Update

Marni Bussell, SIM Project Director
1. Require Value Based Purchasing (VBP) and Common Quality Measurements

- 40% of MCO population must be included in VBP by 2018
- Value Index Score (VIS) as the delivery system across the MCOs
- VIS already understood and in use by delivery system as a basis for VBP programs
- Not dictating actual payment terms leaves flexibility for the MCOs

2. Align Delivery System Quality with MCO Quality

- MCO success measure (VIS) same as the delivery system
- Both MCO and delivery system are driving the same metrics for care coordination
- Alignment can help reconcile the tension in “competing” sets care coordination efforts
- Underscore core strategic value: driving population health outcomes
3. Primary Care Practitioner (PCP) Assignment

- Clearly identifies which PCP is accountable for a given member
- Delivery system infrastructure (such as alerts) can be optimized to manage patients
- Enhanced, timely care coordination possible for members that stray out of network

Model Test Objectives

Vision: Transforming Health Care to Improve the health of Iowans

- Improve Population Health
- Transform Health Care
- Promote Sustainability
SIM Current Activity

2015 - Planning and Preparation

- Execute contracts with vendors
  - 3 out of 4 primary contracts complete
  - Hiring in process

- Statewide Alert Notification (SWAN) roll-out for 2015
  - TA Kick-off Webinar for ACO Hospitals - August 13
  - Connecting in September
  - Alerts targeted to start for Medicaid Patients in October

- Provide Technical Assistance to Delivery System
  - August 18 – Kick-off, more than 400 in attendance
  - Community focus events being planned
  - Three state-wide events each year

SIM Kick-off Conference

Five state-wide strategies rolling out

Each focused on:
  - Community Care Coordination
  - Patient and Family Engagement
  - Social Determinants of Health
SIM Activity - Continued

• Establish Community Care Team framework under SIM
  o Focuses on Community Care Coordination, SDH, integrating LPH and PCPs, etc.
  o SIM is funding current activity through December 31, 2015 (through IDPH)
  o IDPH soon to released CCT RPF for 2016

• Align Value-based Purchasing in Medicaid with other payers
  o MCO Announcement on August 17, 2015
  o See earlier slides

SIM Activity - Continued

Public Stakeholder meetings
• MAAC – Regular agenda item
• Continue to speak at association, leadership, advisory meetings on demand
• SIM Leadership team convening

2015 Deliverables (to CMMI)
• Stakeholder Engagement Plan – March 30
• Quarterly Activity Reports – May, August and November
• Operational Plan – December 1
SIM Partners

Iowa Healthcare Collaborative

IDPH

Iowa Department of Human Services

healthiest — state — initiative

Resources

Website:
http://dhs.iowa.gov/ime/about/state-innovation-models

Emails:
mbussel@dhs.state.ia.us
IA Health Link
Member/Provider Transition Update

Andria Seip,
Medicaid Program Integrity Director

September 2, 2015

Member Activities

- Member Populations
- Member Benefits
- DHS Member Outreach & Education
- Stakeholder Outreach & Assistance
- Member Enrollment

Member Enrollment Activities

Overview of Process
Step 1: Introductory Mailing
Step 2: Tentative MCO Assignment
Step 3: MCO Contacts Member
Step 4: New Member Enrollment
Step 5: New Member HCBS Waiver
Step 6: MCO Changes for ‘Good Cause’
Step 7: Enrollment Broker Role
Member Populations

Included:
- Majority of Medicaid members
- Low income families and children
- *hawk-i*
- Iowa Health and Wellness Plan
- Long Term Care
- HCBS Waivers

Excluded:
- PACE - can opt in to MCO
- Programs where Medicaid already pays premiums: HIPP, Medicare Savings Program only
- Medically Needy
- American Indians/Alaskan Natives (members can opt-in)
- Undocumented persons eligible for short-term emergency services only

Member Benefits

- Physical health care in inpatient and outpatient settings, behavioral health care, transportation, etc.
- Facility-based services such as Nursing Facilities, Intermediate Care for Persons with Intellectual Disabilities, Psychiatric Medical Institution for Children, Mental Health Institutes and State Resource Centers
- Home and Community-Based Services (HCBS) waiver services
- Dental services are “carved out” – continue same as today
DHS Member Outreach & Education

- Tele-townhall meetings
- Events and trainings
- Newsletters
- Member educational materials
- Member mailings
- Earned media
- Community partnerships
- Coordination with stakeholders and providers
- Advisory and member-based focus groups
- Website content
- Webinars

Stakeholder Outreach & Assistance

- Stakeholder toolkit will be available online and to all stakeholders to support accurate information in the transition to current Medicaid members
- Posted week of September 8
- Information includes:
  - IA Health Link Program Overview
  - Links to FAQs, Factsheets and DHS Website updates
  - Help in selecting an MCO Materials
  - Member Promotional Materials
  - Member Introductory Mailings
MCO Stakeholder Outreach

- MCOs have begun to reach out to stakeholders to assist in promoting an understanding of managed care benefits
- DHS must approve public facing materials such as marketing materials and member letters
- DHS has held stakeholder meetings with more to come, webinars upcoming including enrollment help

Member Enrollment Activities

Overview of Enrollment Process

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Introductory Mailings by population</td>
<td>MCO Enrollment Begins</td>
<td>Enrollment assistance continues</td>
<td>December 17, 2015: Last Day to Make MCO Choice for January 2016</td>
<td>January 1: Begin Coverage with MCO</td>
<td>March 19: Member must have Good Cause to make change</td>
<td></td>
</tr>
</tbody>
</table>

December 18, 2015 - March 18, 2016: Member can change MCO without Good Cause
Step 1: Introductory Mailings

- Introductory mailings sent to members per the following schedule, and posted online:
  - Week of August 31: Long Term Care
  - Week of September 8: hawk-i
  - Week of September 8: Other Medicaid groups
  - Week of September 21: Current managed care members
- Mailings will include:
  - Timeline
  - FAQ
  - Links to education materials, toolkits online
  - Contacts for questions

Step 2: Tentative MCO Assignment

Member enrollment packets mailed October through November
- Tentative assignment included and based on algorithm to keep families together under one MCO
- Staggered mailing by program enrollment similar to introductory mailing
- Current members have until December 17 to choose for January 2016, with an additional 90 days after the January assignment to change MCOs for any reason
- DHS notifies MCO of selection through enrollment file
Step 3: MCO Contacts Member

MCOs will distribute enrollment materials to new members within 5 business days of receipt of member enrollment selection.

- Examples of enrollment materials:
  - Provider directory
  - MCO contract information
  - Services available
  - Grievance and appeal information
  - Member protections, rights, and responsibilities
  - Information on how to contact the Enrollment Broker
  - Contact information and role of the Ombudsman

Step 4: New Member Enrollment

- Starting December 8, 2015, and ongoing, the date of eligibility for new members will impact the date they are enrolled with an MCO.
  - This is because there is a point in which there is a IT system cut off to review to the MCO to ensure the beginning of the month capitation.
- When the member is eligible but is unable to be enrolled in the MCO in the month in which they apply - services will be paid for by the Medicaid Fee for Service program until they are enrolled with the MCO the following month.
  - Both medical and behavioral services.
Step 5: New Member - HCBS Waiver

- Slots will continue to be authorized through approval of waiver applications and state legislation
- DHS will continue to manage the waiting list and assignments
- Some members are not Medicaid eligible prior to being given an HCBS waiver slot. The department is in the process of determining how best to implement HCBS services in these instances
  - Timing of level of care determination
  - Financial determinations
  - Service planning critical to MCO assignment and member choice

Step 6: MCO Changes for ‘Good Cause’

- Members may disenroll from their MCO at any time throughout the year for reasons of “good cause”
- “Good cause” reasons can include:
  - A member’s provider is not enrolled with the MCO and that provider disenrollment impacts the members’ health outcomes
  - A member needs related services to be performed at the same time and not all related services are available in the MCO network
  - If there is a change in eligibility (for example PACE)
Good Cause Cont.

• To make a change:
  • Members call the Iowa Medicaid Enrollment Broker to request disenrollment for "good cause"
  • Members tell the Enrollment Broker which MCO they want to switch to
  • If a member has a question about whether they have a "good cause" they can call the Enrollment Broker for more information

Enrollment Broker Role

• MAXIMUS will be the Enrollment Broker and is responsible for providing information and conflict free choice counseling for members in the selection of a MCO
• Key activities to share information and support member selection of MCO:
  ▪ In-person meetings throughout state with special focus on long term care members, schedules upcoming and posted online
  ▪ Email: IMEMemberServices@dhs.state.ia.us
  ▪ Call Center: 1-800-338-8366, 8am-5pm, M-F
  ▪ Members can select their MCO through voice system option 24/7 daily. Can leave message for call back
Enrollment Broker Role Cont.

The Enrollment Broker will offer health plan choice counseling to members. Choice counseling includes answering member questions about each health plan such as:

- Is my provider in the MCO network?
- Is my pharmacy in the MCO network?
- Does the MCO have specialists close to my community?
- Does the plan have value-added services that would benefit me?
- Are there special health programs that would help me?
- Does the MCO have call centers or helplines available beyond regular business hours?

IA Health Link Provider Activities

- MCO Provider Network Requirements
- Case Management Requirements
- Provider Education and Training, Resources
- Provider Enrollment Process Overview
- DHS Enrollment Timeline
- DHS Provider Enrollment Renewal
- MCO Provider Enrollment
- MCO Provider Enrollment Timeline
  - Questions and Answers
MCO Provider Network Requirements

Physical & Behavioral
- MCOs will use all current Medicaid providers for the first six months
- MCOs network effective July 1, 2016
- Strict network adequacy

Waiver & Long Term Care
- MCOs will use all current LTC waiver providers, if they contract with the MCO, for the first two years
- MCO network effective January 1, 2018
- Strict network adequacy

MCO Network Requirements Cont.
- MCOs must have an adequate provider network as defined in the MCO contracts with DHS
  Example Access Standards:
  - PCP – Within 30 minutes or 30 miles from all members
  - Specialists – Within 60 minutes or 60 miles for at least 75 percent of the members
  - HCBS – Within 30 minutes or 30 miles from members in urban counties and 60 minutes or 60 miles from members in rural counties
- An MCO must use non-network providers if there is a gap in coverage for a particular service
- MCOs are to extend authorization of long term care services from an out-of-network provider to ensure continuity of care
MCO Network Requirements Cont.

- MCOs are working to sign agreements with providers. For more information:
  - Amerigroup: page 1461 of proposal
  - Amerihealth: page 1278 of proposal
  - United: page 1273 of proposal
  - Wellcare: page 1103 of proposal
- DHS must approve all MCO provider contract templates
- Iowa Medicaid Informational Letter 1539 gives current Medicaid providers information on MCO contacts for MCO provider enrollment

MCO Case Management Requirements

- Members able to keep their current case management agency until at least June 30, 2016, as long as provider(s) choose to participate with the MCOs
- All case management activities must be transitioned to the MCOs no later than December 31, 2016
- MCOs will determine how to manage case assignments for community-based case management
- MCOs may provide community-based case management themselves or sub-contract with current case managers and must ensure staff maintains appropriate credentials, education, experience and orientation
DHS Provider Education and Training

- Statewide training in 11 locations across Iowa in September
- Provider toolkits available early September 2015
- Tele-townhall meetings
- Events and trainings
- Monthly newsletters
- Provider educational materials updated continually
- Stakeholder emails
- Informational Letters 1537 and 1539 and upcoming

Annual Provider Training Schedule

<table>
<thead>
<tr>
<th>Location</th>
<th>Date</th>
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</thead>
<tbody>
<tr>
<td>Sioux City</td>
<td>Monday, September 14</td>
</tr>
<tr>
<td>Council Bluffs</td>
<td>Tuesday, September 15</td>
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<tr>
<td>Bettendorf</td>
<td>Wednesday, September 16</td>
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<tr>
<td>Burlington</td>
<td>Thursday, September 17</td>
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<tr>
<td>Fort Dodge</td>
<td>Monday, September 21</td>
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<tr>
<td>Mason City</td>
<td>Tuesday, September 22</td>
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<tr>
<td>Waterloo</td>
<td>Wednesday, September 23</td>
</tr>
<tr>
<td>Cedar Rapids</td>
<td>Thursday, September 24</td>
</tr>
<tr>
<td>Dubuque</td>
<td>Monday, September 28</td>
</tr>
<tr>
<td>Ottumwa</td>
<td>Tuesday, September 29</td>
</tr>
<tr>
<td>Des Moines</td>
<td>Wednesday, September 30</td>
</tr>
</tbody>
</table>
Provider Education and Training Cont.

• Provider Toolkit will be posted the week of September 8:
  o Intro letter and project overview
  o General provider questions/FAQ
  o Provider MCO enrollment information
  o Annual provider training schedule and information
  o Member mailing summary
  o Sample member FAQs
  o Sample member newsletter content
  o Contact information for questions (for providers and members)
    o Member introductory mailings

Provider Information Resources

• IME Website
  http://dhs.iowa.gov/ime
  Modernization specific information:
  http://dhs.iowa.gov/ime/about/initiatives/MedicaidModernization

• Iowa Medicaid Provider Services Call Center
  1-800-338-7909 (7:30 a.m. – 4:30 p.m.)

• Email
  Updates through IMEProviderCommunications@dhs.state.ia.us
Provider Enrollment Process Overview

- All in-state and out-of-state providers, whether providing services under MCO or FFS, must enroll with Iowa Medicaid to ensure continuity of care for members
- Providers will enroll with Iowa Medicaid prior to MCO
- MAXIMUS currently carries out the IME provider enrollment process
- DHS will collaborate with MCOs to develop a provider enrollment process that is as streamlined and as efficient as possible for providers

DHS Enrollment Timeline

MCO networks are effective July 1, 2016. Over the next six months IME will:

- Enroll behavioral care providers previously enrolled in Magellan
- Enroll providers in the MCO networks who have not previously been enrolled in Iowa Medicaid
- Implement a provider enrollment renewal process
  - Schedule will be announced by Informational Letter
  - Providers may scan updated paperwork to the new enrollment email address
    - IMEProviderEnrollment@dhs.state.ia.us
DHS Provider Enrollment Renewal

- Per ACA requirements, IME is required to conduct increased licensure verification and database checks than it has in the past
- The volume of Iowa Plan providers and MCO providers that are newly enrolling impacts the scheduled re-enrollment capacity
- Due to the number of providers that will be impacted, IME is beginning a staged rollout process
- Informational letters and training will be available to relevant providers at the time of the staged rollout
- The goal is to re-enroll all current health care providers over the next year while also beginning the HCBS waiver provider recertification process

MCO Provider Enrollment

- Each MCO will develop its provider network, enrolling all current Medicaid providers when possible
- DHS will provide Medicaid provider enrollment information to each MCO to assist in preventing a duplication of efforts for providers
- MCOs will each have their own credentialing process to meet their accreditation standards
- If an MCO recruits a new provider, it will be expected to assure that provider is also enrolled by IME
- Out-of-state and other non-contracted providers may enter into single case agreements with providers as necessary to serve the needs of members in special situations
Provider Enrollment Timeline

<table>
<thead>
<tr>
<th>Duration</th>
<th>Section 1</th>
<th>Section 2</th>
<th>Section 3</th>
<th>Section 4</th>
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<tbody>
<tr>
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Questions & Answers
### Member Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
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</thead>
<tbody>
<tr>
<td>What if I missed the cutoff to change my MCO?</td>
<td>Please call the Member Services Unit at 1-800-338-8366</td>
</tr>
<tr>
<td>What if my provider isn’t in my selected network?</td>
<td>You may use the 90-day period to select an MCO in which your provider is accessible to you</td>
</tr>
<tr>
<td>What if I don’t like my MCO and want to change?</td>
<td>After January 1, 2016, you have 90 days to choose a different MCO, then you will stay with your MCO unless for good cause</td>
</tr>
<tr>
<td>Will my family be part of my MCO?</td>
<td>Families can choose to be in the same MCO, tentative assignment are made to do just that</td>
</tr>
</tbody>
</table>

### Member Questions Cont.

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Will members still pay premiums if they do so today?</td>
<td>Yes, per existing requirements</td>
</tr>
<tr>
<td>Will there be appeal rights?</td>
<td>Yes, with the MCO and then the state</td>
</tr>
<tr>
<td>Will my benefits change? If my level of care changes, who do I contact for review?</td>
<td>Benefits stay the same unless level of care needs change or eligibility changes. Members can contact Member Services for more information about benefits</td>
</tr>
<tr>
<td>Who authorizes services?</td>
<td>MCOs do. Based on state policy and administrative rule, the state reviews if level of care changes</td>
</tr>
</tbody>
</table>
### Provider Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>How will service authorizations work?</td>
<td>MCOs will honor existing service authorizations for at least 3 months</td>
</tr>
<tr>
<td>How does claims payment work?</td>
<td>MCOs are required to pay within similar timeframes that Medicaid currently pays</td>
</tr>
<tr>
<td>How many networks can providers be a part of?</td>
<td>Providers can be part of all of the networks, or just one. Networks, however, must be statewide</td>
</tr>
<tr>
<td>What about utilization management?</td>
<td>MCOs are responsible for utilization management, and their policies must be approved through DHS</td>
</tr>
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</table>

### Provider Questions Cont.

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>When can I start working with MCOs?</td>
<td>Providers may begin working with the MCOs immediately</td>
</tr>
<tr>
<td>How do I get in contact with them?</td>
<td>See Informational Letter 1539 for contacts for each MCO</td>
</tr>
<tr>
<td>Will the enrollment paperwork across MCOs be the same?</td>
<td>Iowa Medicaid’s enrollment application will be the same, but the MCOs may have additional requirements</td>
</tr>
</tbody>
</table>
More information

Please visit our website at http://dhs.iowa.gov/ime/about/initiatives/MedicaidModernization for updates, fact sheets, FAQs and more

To receive email alerts with news and information about Medicaid Modernization, send an email with the subject line 'subscribe' along with your name, organization and email address to IMECommunications@dhs.state.ia.us.

United Healthcare

NANCY LIND
AmeriHealth Caritas Family of Companies

Introduction and Overview

Lisa Baker
Corporate Account Executive

Sheron Rankins
Corporate Director, New Business Network
Development

Who We Are

A leading Medicaid managed care company with a unique mission-driven approach to care.

• A differentiated model of care operating in 16 states and the District of Columbia, serving 6.9 million members through a variety of services.

• Strong experience in managing medically frail and complex populations.

• Experience with the Temporary Assistance for Needy Families (TANF) population since 1983 (d.b.a. Mercy Health Plan).

• Aged, Blind and Disabled (ABD) population since 1997 (d.b.a. AmeriHealth Mercy).

• Selected in two states to participate in the Medicare-Medicaid pilot demonstration program.

• Supports provider-sponsored health plans in Kentucky (since 1997) and Indiana (since 2004)

AmeriHealth Caritas has evolved from its early days as a small provider-owned, community-based Medicaid health plan, but our mission remains the same...

We help people get care, stay well and build healthy communities.

Our vision: Leading America in health care solutions for the underserved.
Integrated Care Through Multiple Product Lines

- Medicaid managed care (TANF/CHIP/ABD)
  - Full-risk.
  - Non-risk (MSA/ASA/TPA).
- Medicare services for duals eligibles
  - Dual Eligible Special Needs Plans (D-SNPs).
  - Medicare-Medicaid Plans (MMPs).
- Behavioral health care
- Pharmacy health care
  - Pharmacy benefits management (PBM) services.
  - Medication therapy management services.
  - Specialty pharmacy services.

AmeriHealth Caritas Has an Expanding National Footprint

AmeriHealth Caritas Coverage Area
Touching the lives of more than 6.9 million members nationwide

- D-SNP
- MHP
- Pharmacy benefits management.
- Behavioral health managed care
- Medicaid third-party administration
- New States EBorder Area/AmeriHealth Caritas Medicaid members
The AmeriHealth Caritas Integrated Care Model

- Our Integrated Care Model blends physical health, behavioral health, long-term services and supports (LTSS) and pharmacy services through a holistic model of care that uses a population-based health management program to provide comprehensive care management services.
- We have a unique set of tools and experiences that drive our exceptionally high-quality and cost-effective approach to LTSS.
- AmeriHealth Caritas uses an interdisciplinary, member-centered approach that focuses on all aspects of a member’s wellness, including social supports.
- Our Integrated Care Model ultimately drives better outcomes for our members and lowers costs for our state-partners.

Person-Centered Approach

With 30 years of experience serving Medicaid populations, AmeriHealth Caritas understands the needs of at-risk populations. Our person-centered approach includes:
- Engaging, educating and empowering members to actively participate in improving their health outcomes.
- Providing members with the information they need to improve and manage their health.
- Involving members, parents or guardians, care team members, providers, behavioral care providers, social services and community group representatives in the care planning and management process.
- Utilizing community-based services to avoid or delay institutional-based care, supporting members who desire to remain in the home and community-based setting.
- Incentivizing and rewarding healthy member-specific behaviors.
PerformPlus® Value-Based Programs

PerformPlus is a portfolio of value-based incentive programs designed to encourage the right care at the right place. Provider groups, hospitals and integrated delivery systems are rewarded for achieving key performance indicators built around adherence to evidence-based clinical practices, achieving targeted quality outcome measures and providing cost-effective, appropriate care.

- Reward program for physicians for timely, appropriate ambulatory care and positive patient outcomes; utilizing peer and trend-based measurements, including HEDIS measures, to determine outcomes and link to rewards.
- Reimbursement incentives based on performance for closing gaps in care for agreed-upon HEDIS measures and other quality metrics, including:
  - High-quality and cost-effective care.
  - Member service and convenience.
  - Accurate and complete health data.

More than 40 percent of our managed care membership across all markets receives care from a provider that participates in one or more of our PerformPlus value-based programs.

Member Engagement Programs

Bright Start®
- Prenatal maternity program that provides support for members who are pregnant.
  - Educational materials and promotion of the use of 17-P.
  - Outreach calls and events, including Community Baby Showers.
  - Moms2be (federal lifeline phones and care management support).

4 Your Kids Care
- Focused education for mothers of young children.
  - How to care for a sick child.
  - When to call the primary care provider (PCP).
  - Importance of regular PCP visits.
  - Group setting fosters sharing and empowerment.

Healthy Hoops®
- Innovative childhood asthma and obesity management program.
- Approved by the National Committee for Quality Assurance (NCQA).
- The program has demonstrated decreases in inpatient and emergency room (ER) utilization, an increase in the use of prevention inhalers and a decrease in the use of rescue medications.
Technology and Innovation

Contact Center of Excellence (CCOE)

Our contact centers utilize innovative technologies and dashboard tools to engage with members and providers. Both Member Services and Care Management teams have access to the same alerts and data, allowing for collaboration of care and closure of care gaps. These tools further enable members to take control of their health, providing support and coaching to facilitate desired action.

Mobile technology

Employing mobile technology to provide real-time, on-demand member access to benefits information, medication history, ID cards, provider directory with geo-location tools, PCP information as well as sending reminders to address potential gaps in care.

Track Record of Achievement

NCQA Health Plan Accreditation
- AmeriHealth Caritas Pennsylvania (since 2001)
- Keystone First (since 2001)
- Select Health of South Carolina (since 2010 – previously certified by URAC)
- AmeriHealth Caritas Louisiana (since 2013)
- Arbor Health Plan (interim 2013)
- AmeriHealth Caritas District of Columbia (interim 2014)

NCQA Multicultural Health Care Distinction
- AmeriHealth Caritas Pennsylvania (since 2010)
- Keystone First (since 2010)
- Select Health of South Carolina (since 2010)
- AmeriHealth Caritas health plans were three of the first seven plans to receive NCQA’s Multicultural Health Care distinction.

NCQA Managed Behavioral Healthcare Organization Accreditation
- PerformCare

URAC Accreditation
- PerformRx
Summary

AmeriHealth Caritas is a leading Medicaid managed care company that is uniquely mission-driven.

AmeriHealth Caritas will continue to serve as a strong partner with its state government and providers, and remain an active advocate for members to ensure they get appropriate health care in the right settings.

AmeriHealth Caritas will further leverage its position to be the consistent thought leader for the industry and recognized as leading America in health care for the underserved.

AmeriHealth Caritas will remain focused on helping people get care, staying well and building healthy communities.
Amerigroup Iowa and the
High Quality Healthcare Initiative
Iowa Safety Net Advisory & Leadership Group
September 3, 2015

Purpose Statement
Together, we are transforming health care with trusted and caring solutions

OUR MEMBERS

<table>
<thead>
<tr>
<th>1 in 9 Americans</th>
<th>37 million total medical members</th>
</tr>
</thead>
</table>

Diverse customer base
- Local group 41%
- Individual 5%
- Medicare 19%
- FEP 14%
- Medicaid 13%

14 states BC or BCBS plan
19 states Medicaid presence
$73B total operating revenue
68M individuals served

$160 million in grants to local and national initiatives since 2000

$5.6 million pledged associate giving (including Foundation match)

$45.9 million active dollars in local communities

Anthem Inc. Fast Facts
Anthem’s Government Business Division

Anthem affiliated health plans serve 8.7 million people in state and federal government health programs, including:

- Over 240,000 MLTSS program members in eight states
- Older adults
- Low income families
- People with disabilities
- Other government-sponsored enrollees
- Medicare plans in 21 states
- Medicaid plans in 19 states

About Amerigroup Iowa

- Amerigroup Iowa is our 20th Medicaid managed care organization (MCO)
- One of four MCOs participating in Iowa’s HQHI Medicaid modernization program
- Finalizing permanent office space in West Des Moines, evaluating possible locations in other Iowa cities
- Transitional leadership
  - Dr. Tunde Sotunde, CEO; John Crowley, COO; Aimee Daily, CFO; and Dr. John Chang, medical director; plus 17 other key staff
- Recruiting for permanent staff; several start later this month
- Iowa staffing plan: 340 associates based in Iowa, 550 total staff
Provider Network Contracting

- High Quality Healthcare Initiative program design includes continuation of services provisions
  - All current Medicaid providers are considered “participating providers” for the first year of the program
  - MCOs will cover current services/episodes of care for from 90 to 365 days (depending on service), paid at Medicaid rates
- Amerigroup is contracting with existing Medicaid providers throughout Iowa; first contracts sent week of August 17th
  - Acute care providers (e.g. hospitals, physicians, diagnostic services, FQHCs, home health)
  - LTSS providers (e.g. HCBS, personal care, residential care, nursing facility, assisted living, CILs, AAAs)
  - Behavioral health (e.g. mental health professionals, IHHs, CMHCs, PMICs)
  - ID/DD service providers (e.g. ICF/DD, habilitation services, residential care)
  - Coordinating with MDHS regions, public health departments

Questions and Discussion

Thank you for working with us!

Amerigroup
An Anthem Company

For more information, please contact:
mark.padilla@amerigroup.com
HealthConnections
Presented by Mackie Hicks
Director Advocacy & Community Based Programs

WellCare Health Plans, Inc.

Company Snapshot

OUR PRESENCE

Data is per the last reported quarter, ending March 31, 2015
Updated: July 1, 2015

Founded in 1985 in Tampa, Fla.:
• Serving approximately 3.8 million members nationwide.
• 320,000 contracted health care providers.
• 70,000 contracted pharmacies.
Serving ~2.4 million Medicaid members, including:
• Aged, Blind and Disabled (ABD).
• Children’s Health Insurance Program (CHIP).
• Family Health Plus (FHP).
• Supplemental Security Income (SSI).
• Temporary Assistance for Needy Families (TANF).
Serving ~1.5 million Medicare members, including:
• 382,000 Medicare Advantage members.
• 1.1 million Prescription Drug Plan members.
Serving the full spectrum of member needs:
• Dual-eligible populations (Medicare and Medicaid).
• Managed Long Term Care (MLTC).
Spearheading efforts to sustain the social safety net:
• The WellCare Community Foundation.
• Advocacy Programs.
• Creation of Public-Private Partnerships.
Significant contributor to the national economy:
• A FORTUNE 500 and Barron’s 500 company.
• Approximately 6,700 associates nationwide.
• Offices in all states where the company provides managed care.
At WellCare, our members are our reason for being.

We work each day to enhance our members’ health and quality of life.

- Emphasis on lower income populations and value-focused benefit design.
- Communication among members and providers to improve outcomes.
- Focus on preventive care including regular doctor visits.
- Community-based solutions to close gaps in the social safety net.

Data is per the last reported quarter, ending March 31, 2015
Updated: July 1, 2015

Elements of a Strong Model

- Engaging Community Partners in Health
- Aiding Social Service Access and Use
- Evaluating Social Service Impact
WellCare Addresses All Health Factors Leading to Positive Health Outcomes

Community Advocacy

Social and economic factors create barriers to positive health outcomes.

To address member needs and strengthen the communities we serve, Community Advocacy identifies gaps in the social safety net and works with local communities to fill the gaps.

CommUnity Command Center

A collection of databases used to refer members and their families to community-based programs and services such as food banks, shelters, parenting classes. Contains information on social services, community activities, health/wellness programs, and Community Health Investments.

Background

- Block Grant-funded programs represent the majority of social safety net services offered to disadvantaged and elderly populations and individuals with disabilities, in part to address social barriers to accessing healthcare
- While struggling to recover from the Recession, states are seeking 1) innovative ways to quantify the impact of social safety net services and 2) solutions to sustaining the network itself
- Lack of access to information about community-based programs and services is a documented pain-point for providers, including WellCare contracted providers

Up to $5.8B in Federal Funding for Social Safety Net programs is at risk.

The 2014/2015 Community Development Block Grant is funded at $2.8B annually, down 53% from 2009.

In 2014, the House Ways and Means Committee proposed eliminating the Social Services Block Grant entirely.

<table>
<thead>
<tr>
<th>Community Development</th>
<th>Social Service</th>
</tr>
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<tbody>
<tr>
<td>Emergency Shelters</td>
<td>Nutrition Programs (SNAP)</td>
</tr>
<tr>
<td>Homeless Programs</td>
<td>Job-related Programs</td>
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<tr>
<td>Rural Housing Support</td>
<td>Disability Programs</td>
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<td>Child-care Programs</td>
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<td></td>
<td>Senior Programs</td>
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<td>Adult Day Activity Centers</td>
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Elements of the HealthConnections Model

- CommUnity Activities
- Social Service Utilization Support (Referral Tracking)
- CommUnity Health Initiatives
- Health Connections Councils

- 28,000 activities reaching 2.6M people
- Closed 1,250 social service network gaps
- Managed 170 Community Initiatives
- 8,800 people referred to 22,000 services

Data-Informed Engagement

Create Integrated Community Focused Strategy using Public Health Data as Foundation

1. Identify public health trends related to population.
2. Overlay social service, referral / gap and community activity data.
3. Compare with related WellCare-specific data like provider network, diagnosis and encounters.
4. Develop an integrated, community-focused response with cross-functional team.
5. Evaluate integrated strategy including CommUnity Health Initiatives.
### Two Examples

<table>
<thead>
<tr>
<th>Homeless Outreach</th>
<th>Healthy Food Access Program</th>
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<tbody>
<tr>
<td>• <strong>Phase I</strong>: Homeless Outreach Program supporting 200 homeless residents; connecting 50 (25%) to permanent housing.</td>
<td>• <strong>Phase I</strong>: Funded Double Dollars and Vouchers when used for healthy food options at Farmer’s Market.</td>
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<td>• <strong>Phase II</strong>: Launched a Street Medicine Pilot in July, 2014; assisted more than 425 homeless residents.</td>
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<td>o Found 66 WellCare “Unable to Contact” Members.</td>
<td>o 90% of participants increased their purchase of fruits/vegetables.</td>
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<td>o More than 40 WellCare members avoided the Emergency Room.</td>
<td>o 95% of vendors agreed that WellCare’s Healthy Food Access Program increased the availability of healthy food options to underexposed neighborhoods.</td>
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<td>• <strong>Phase III</strong>: Expand the Street Medicine Pilot to four teams to reach 600 individuals.</td>
<td>o 100% of vendors reported increased sales.</td>
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<td>• <strong>Phase II</strong>: With WellCare’s support, Farmers Market secured a $50,000 USDA grant.</td>
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