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State Innovation Models (SIM) Round 2

Model Test Annual Report One

Submitted to

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Acronym List

ACA	Affordable Care Act
ACC	Accountable Care Collaborative
ACH	Accountable Community of Health
ACN	Accountable Care Network
ACO	accountable care organization
ACR	active care relationship
ACS	American Community Survey
ADT	admission, discharge, and transfer
AHRQ	Agency for Healthcare Research and Quality
AIM	Analytics, Interoperability, and Measurement
AMH	Advanced Medical Home
AN	Advanced Network
APC	Advanced Primary Care (New York)
APCD	all-payer claims database
APD	All-Payer Database (New York)
APM	alternative payment model
APRN	advanced practice registered nurse
ASC	Accountable Systems of Care
ASO	Administrative Services Organization
BCBS	Blue Cross Blue Shield
BCBSRI	Blue Cross Blue Shield of Rhode Island
BHDDH	Department of Behavioral Health, Developmental Disabilities, and Hospitals
BH	behavioral health
BHO	behavioral health organization
BIP	Balancing Incentive Program
BMI	body mass index
BPCI	Bundled Payments for Care Improvement
BRFSS	Behavioral Risk Factor Surveillance System
C3	Community Care Coalition
CAB	Consumer Advisory Board
CAH	critical access hospital
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CBHC	Colorado Behavioral Health Council
CBO	community-based organization

CBPI	community-based performance improvement
CC	care coordination
CCD	continuity of care document
CCBHC	Certified Community Behavioral Health Center
CCIP	Community and Clinical Integration Program
CCT	care coordination tool
CDC	Centers for Disease Control and Prevention
CDPHE	Colorado Department of Public Health & Environment
CDS	clinical decision support
CEO	chief executive officer
CFR	<i>Code of Federal Regulations</i>
CHC	community health center
CHCP	Comprehensive Health Care Program (Michigan)
CHCS	Center for Health Care Strategies
CHEMS	community health emergency medical services
CHIP	Children’s Health Insurance Program
CHIR	Community Health Innovation Region
CHITA	clinical health IT advisor
CHNA	Community Health Needs Assessment
CHNA&HIP	Community Health Needs Assessment and Health Improvement Plan
CHT	community health team
CHW	community health worker
CLN	Collaborative Learning Network
CM	care management
CMCS	Centers for Medicaid and CHIP Services
CMHC	community mental health center
CMMI	Center for Medicare and Medicaid Innovation
CMS	Centers for Medicare & Medicaid Services
CORE	Yale University’s Center for Outcomes Research and Evaluation
CPC+	Comprehensive Primary Care Plus
CPCi	Comprehensive Primary Care initiative
CQM	Core Quality Measure
CTC	Care Transformation Collaborative
CTC-RI	Care Transformation Collaborative of Rhode Island
DCHI	Delaware Center for Health Innovation
DCS	Department of Civil Service

DCYF	Department of Children, Youth, and Families
DFS	Department of Financial Services
DHIN	Delaware Health Information Network
DHS	Department of Human Services
DMHAS	Department of Mental Health and Addiction Services
DO	Doctor of Osteopathic
DOA	Department of Administration
DOH	Department of Health
DOI	Department of Insurance
DORA	Department of Regulatory Agencies
DPH	Department of Public Health
DSHS	Department of Social and Health Services
DSRIP	Delivery System Reform Incentive Payment
DSS	Department of Social Services
DUA	data use agreement
ECF	Employment and Community First
EHR	electronic health record
EMS	emergency medical services
EOC	episode of care
EOHHS	Executive Office of Health and Human Services
ER	emergency room
ERISA	Employee Retirement Income Security Act
FFM	federally facilitated marketplace
FFS	fee-for-service
FPL	federal poverty level
FQHC	Federally Qualified Health Center
GDP	gross domestic product
GME	graduate medical education
HAI	health care–associated infection
HB	House Bill
HCA	Health Care Authority
HCBS	home- and community-based services
HCC	Health Care Commission
HCFA	Health Care Financing Administration
HCIA	Health Care Innovation Awards
HCPF	Colorado’s Department of Health Care Policy & Financing

health IT	health information technology
HEC	Health Enhancement Community
HEDIS	Healthcare Effectiveness Data and Information Set
HHS	United States Department of Health and Human Services
HIE	health information exchange
HILN	Health Innovation Leadership Network
HIP	Health Improvement Plan
HIPAA	Health Insurance Portability and Accountability Act
HITECH	Health Information Technology for Economic and Clinical Health
HL	Health Link
HMO	health maintenance organization
HN	Healthy Neighborhood
HPIO	Health Policy Institute of Ohio
HPSA	Health Professional Shortage Area
HRSA	Health Resources and Services Administration
I/DD	intellectual and developmental disabilities
ICD-10	International Classification of Diseases-10
IDHS	Iowa Department of Human Services
IDHW	Idaho Department of Health and Welfare
IDPH	Iowa Department of Public Health
IHC	Idaho Healthcare Coalition
IHDE	Idaho Health Data Exchange
IHIN	Iowa Health Information Network
IHS	Indian Health Services
IME	Iowa Medicaid Enterprise
IMHC	Idaho Medical Home Collaborative
IPA	Independent Practice Association
IPCA	Iowa Primary Care Association
LAN	Learning and Action Network
LPH	local public health
LPHA	local public health agency
LTPAC	long-term and post-acute care
LTSS	long-term services and supports
M	million
MAAC	Medical Assistance Advisory Council
MACRA	Medicare Access and CHIP Reauthorization Act of 2015

MAPCP	Multi-Payer Advanced Primary Care Practice
MAPOC	Council on Medical Assistance Program Oversight, referred to as the Medical Assistance Program Oversight Council
MCO	managed care organization
MD	medical doctor
MDCH	Michigan Department of Community Health
MDHHS	Michigan Department of Health and Human Services
MDS	Minimum Data Set
MFP	Money Follows the Person
MiCHAP	Michigan Children’s Health Access Program
MiHIN	Michigan Health Information Network
MiPCT	Michigan Primary Care Transformation
MIPS	Merit-Based Incentive Payment System
MLR	Medical Loss Ratio
MLTSS	managed long-term services and supports
MMIS	Medicaid Management Information System
MOU	memorandum of understanding
MPC	Multi-Payer Collaborative
MPHB	Michigan Pathways to Better Health
MPIP	Medicaid Provider Incentive Program
MQISSP	Medicaid Quality Improvement Shared Savings Program
MSSP	Medicare Shared Savings Program
N/A	not applicable
NCQA	National Committee for Quality Assurance
NEBGH	Northeast Business Group on Health
NEPQR	Nurse Education, Practice, Quality, and Retention
NF	nursing facility
NGA	National Governor’s Association
NICU	neonatal intensive care unit
NP	nurse practitioner
NQF	National Quality Forum
NYEC	New York eHealth Collaborative
NYSDOH	New York State Department of Health
OASIS	Outcomes and Assessment Information Set
OBH	Office of Behavioral Health
OHA	Office of the Healthcare Advocate

OHIC	Office of the Health Insurance Commissioner
OHT	Office of Health Transformation
ONC	Office of the National Coordinator for Health Information Technology
P4IPH	Plan for Improving Population Health
P4P	pay-for-performance
P4V	pay for value
PA	physician's assistant
PACE	Programs of All-Inclusive Care for the Elderly
PAP	principal accountable provider
PBM	Pharmacy Benefits Manager
PCCM	Primary Care Case Management
PCMH	patient-centered medical home
PCMH+	Person Centered Medical Home Plus
PCMI	Program on Chronic Mental Illness
PCP	primary care provider
PDSA	Plan-Do-Study-Act
PEBB	Public Employee Benefits Board
PGIP	Physician Group Incentive Program
PHD	Public Health District
PHI	protected health information
PHO	Physician Hospital Organization
PMO	Project Management Office
PMPM	per member per month
PO	Physician Organization
PPS	Performing Provider System
PSC	Prevention Service Center
PTO	Practice Transformation Organization
PUMS	Public Use Microdata Sample
QHP	qualified health plan
QIN-QIO	Quality Innovation Network-Quality Improvement Organization
QM	quality management
QMRT	quality measures reporting tool
QMRT+	quality measures reporting tool +
QE	qualified entity
QI	quality improvement
QO	qualified organization

QRS	Quality Reporting System
QuILTSS	Quality Improvement in Long-Term Services and Supports
RAMP	Relationship and Affiliations Management Platform
RC	Regional Health Collaborative
RCCO	regional care collaborative organization
RFA	request for application
RFI	request for information
RFP	request for proposal
RHC	rural health clinic
RHIO	regional health information organization
RIDOH	Rhode Island Department of Health
RIQI	Rhode Island Quality Institute
RN	registered nurse
ROI	return on investment
RPRI	Rural Policy Research Institute
RSA	regional service area
RWJF	Robert Wood Johnson Foundation
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SHIN-NY	Statewide Health Information Network for New York
SHIP	State Health Care Innovation Plan
SIM	State Innovation Model
SMI	serious mental illness
SPA	state plan amendment
SPLIT	Shared Practice Learning and Improvement Tool
SW	southwest
SWAN	Statewide Alert Notification
TA	technical assistance
TAG	Technical Advisory Group
TBD	to be determined
TCAAP	Tennessee Chapter of the American Academy of Pediatrics
TCC	total cost of care
TCPI	Transforming Clinical Practice Initiative
THA	Tennessee Hospital Association
TMA	Tennessee Medical Association
tnREC	Tennessee Regional Extension Center

Uconn	University of Connecticut
VBID	value-based insurance design
VBP	value-based payment
VIS	Value Index Score

Executive Summary

State governments have the potential to accelerate statewide health care system transformation through the many roles they play—as regulators, legislators, conveners, and both suppliers and purchasers of health care services. The Centers for Medicare and Medicaid Innovation’s (CMMI’s) State Innovation Models (SIM) program awarded over \$622 million in Model Test awards to support 11 Round 2 Model Test states—Colorado, Connecticut, Delaware, Idaho, Iowa, Michigan, New York, Ohio, Rhode Island, Tennessee, and Washington. States are using policy and regulatory levers to enable or facilitate the spread of innovative health care models, integrating population health into transformation efforts, engaging a broad range of stakeholders, and leveraging existing efforts to improve health care delivery outcomes. Many of the strategies Round 2 Model Test states are implementing in their SIM awards were developed as part of, or evolved from, the State Health Care Innovation Plans (SHIPs) the states designed during their Round 1 Model Design or Pre-Test awards. States also used their Round 1 awards to build coalitions with key stakeholders. The Model Test awards are for 4 years; Award Year 1 was the preimplementation period, which the states devoted to further refine their SHIPs and develop implementation strategies. Award Years 2, 3, and 4 are the test period, during which the various strategies of the state SHIPs are implemented and evaluated.

For the independent federal evaluation of Round 2 of the SIM Initiative, CMMI contracted with a team led by RTI International—which includes The Urban Institute, National Academy for State Health Policy, Truven Health Analytics, and The Henne Group. This, the first annual report of the SIM Round 2 evaluation contract, analyzes data collected through June 30, 2016. The report describes: (1) the approaches the Round 2 Model Test states are implementing or plan to implement to transform their health care systems, (2) the context in which these 11 states are implementing their approaches, (3) which strategies stakeholders think are likely to have the greatest impact on statewide health and health care use, expenditures, coordination, and quality during the Award Years 2–4; and (4) potential barriers they see in the way of realizing those changes. Sources include qualitative information drawn from monthly evaluation calls with state officials, document reviews, and interviews and focus groups during site visits between April and June 2016. During the period covered (February 1, 2015 to June 30, 2016) in this Year 1 annual report, most states were beginning their SIM test phase. However, in three states (Connecticut, Michigan, and Rhode Island) implementation was delayed, as they finalized their state SIM Operational Plans for Award Year 2.

Findings indicate significant variation in the settings in which states are implementing Round 2 of the SIM Initiative, as well as in their approaches to reform. These differences in settings and approaches may influence the impacts of the SIM awards on the spread of

innovative health care models and on statewide outcomes, as organized by topic area and discussed in the remainder of this Executive Summary.

ES.1 Baseline Characteristics of the State Populations, Health Care Systems, and Insurance Markets

- The Round 2 Model Test states range in population size, according to 2015 statistics, from the seventh smallest state (Delaware, at 959,100 residents) to the fourth largest (New York, with almost 20 million residents) in the United States.
- Few payers outside Medicaid have currently committed to the payment reform models in the SIM Initiatives of the 11 Round 2 Model Test states. Medicaid coverage of the Model Test states ranges between 11 percent and 19 percent; Medicare coverage between 14 percent and 18 percent; and employer coverage between 49 percent and 57 percent. Thus, having 80 percent of the state’s population (preponderance of care) in an alternative payment model, as outlined in the United States Department of Health and Human Services (HHS) Secretary’s directive, will require adoption of delivery system and payment reform, not only by Medicaid, but by Medicare and a substantial number of commercial plans, as well. If the Model Test states are not able to include populations beyond the initial focus on Medicaid in most of the states, this may limit the ability of their SIM Initiatives to help states reach a preponderance of care
- Five of the 11 Round 2 Model Test states (Delaware, Idaho, Iowa, Rhode Island, and Tennessee) operate in concentrated commercial health insurance markets, with one dominant carrier’s share covering two-thirds or more of the market—making it potentially easier for those states to involve a critical mass of the commercial insurance population in health care transformation.

ES.2 Prior and Ongoing Health Care Delivery System and Payment Reform in the States

Prior and ongoing reforms can be both a positive force and a frustration for SIM Initiatives. These reforms distinct from SIM provide (1) an understanding of the importance of transformation, (2) lessons learned that informed the design of the Model Test awards, and (3) a foundation of trust and working relationships with key stakeholders. However, as a New York state official noted, the numerous other initiatives operating or about to be launched in the state can also cause confusion and fatigue among both payers and providers.

- At least seven Round 2 Model Test states (Colorado, Connecticut, Idaho, Iowa, Michigan, New York, and Rhode Island) are starting the SIM Initiative with established patient-centered medical homes (PCMHs) for their Medicaid/Children’s Health Insurance Program coverage; and four states (Colorado, Iowa, New York, and Rhode Island) have established accountable care organizations (ACOs) within their Medicaid programs.

- Round 2 Model Test states are building their SIM Initiatives onto existing state initiatives involving case management, value-based insurance programs, and community care teams.
- Round 2 Model Test states also participated, currently participate, or will soon participate in a large number of federally funded health care reform demonstrations and initiatives, including the Multi-Payer Advanced Primary Care Practice (MAPCP—Michigan, New York, and Rhode Island) Demonstration; Comprehensive Primary Care initiative (CPCi—Colorado, New York, and Ohio); Comprehensive Primary Care Plus (CPC+—Colorado, Michigan, New York, Ohio, Rhode Island, and Tennessee); the Federally Qualified Health Centers (FQHC) Advanced Primary Care Practice Demonstration (Colorado, Connecticut, Idaho, Iowa, Michigan, New York, Ohio, Rhode Island, Tennessee, and Washington); Bundled Payments for Care Improvement (BPCI) Initiative (all Round 2 Model Test states); Transforming Clinical Practice Initiative (TCPI—all Round 2 Model Test states); Health Care Innovation Awards (HCIAs—all Round 2 Model Test states); and Financial Alignment Initiative (Colorado, Michigan, New York, Ohio, Rhode Island, and Washington).
- Some Round 2 Model Test states have reacted to the challenge of having concurrent reforms, by developing SIM Initiative models that complement rather than compete with existing initiatives, and/or using SIM funds to develop policies and infrastructure that coordinate or align the various other initiatives ongoing within the state. For example, to complement its multi-payer PCMH initiative (the Chronic Care Sustainability Initiative), Rhode Island is implementing PCMH Kids to expand its PCMH model to its pediatric population. To enhance care coordination in its existing and new health care transformation activities, Michigan is adding admission, discharge, and transfer notifications to its health information exchange (HIE) (Michigan Health Information Network).

ES.3 Governance and Project Administration

- SIM is administered from a variety of state government offices and agencies—including the Governor’s Office (Colorado), the state’s department of health or health and human services (New York, Idaho, and Michigan), the state’s Medicaid authority (Iowa, Tennessee), the state’s health insurance commission (Rhode Island), and special departments or offices of health care transformation (Connecticut, Delaware, and Ohio). In Washington, SIM is administered by an agency that is both the Medicaid authority and purchaser of coverage for public employees.
- Most Round 2 Model Test states have a steering committee or advisory council, whose membership includes representatives from participating public agencies, as well as major private payers, providers, consumer advocates, employers, and other key stakeholders.
- States also have several multi-stakeholder committees or work groups, focused on development and implementation of specific aspects of the SIM Initiative.

ES.4 Delivery Systems and Payment Reforms

- Nearly every Round 2 Model Test state deployed some form of primary care transformation as part of their delivery reforms. Seven of the 11 Model Test states (Connecticut, Idaho, Michigan, New York, Ohio, Rhode Island, and Tennessee) are establishing or expanding PCMH models. Other delivery system models include health homes (Colorado and Tennessee) and ACOs (Connecticut, Michigan, and Washington).
- All Round 2 Model Test states except Colorado have specified plans to shift payments to providers away from volume-based models. Six of the 11 Model Test states (Connecticut, Michigan, New York, Ohio, Tennessee, and Washington) have plans for some variation of shared savings. Other common payment models include per member per month (PMPM) payments tied to performance (Connecticut, Idaho, Ohio, Rhode Island, and Tennessee) and episodes of care (EOCs—Ohio and Tennessee).
- The Round 2 Model Test states are using a range of policy levers to implement their delivery system and payment reform models. The two most common are Medicaid managed care organization contract requirements (7 of 11 Model Test states—Delaware, Iowa, Michigan, Ohio, Rhode Island, Tennessee, and Washington) and state legislation (5 of 11 Model Test states—Delaware, Ohio, Rhode Island, Tennessee, and Washington). For example, the Washington state legislature enacted several key bills, such as one that established a phased approach for full integration of behavioral health in Medicaid managed care by 2020. The Idaho Governor used an Executive Order to establish the Idaho Healthcare Coalition, which guides implementation of Idaho’s SIM Initiative.

ES.5 Strategies to Address Population Health Improvement

- Stakeholders identified strategies that integrate clinical, public health, and community-based services as the most innovative and most likely to make an impact on population health. Most states’ SIM Initiatives include local or regional entities to identify and prioritize population health needs (8 of 11 Model Test states—Colorado, Connecticut, Delaware, Idaho, Iowa, Michigan, New York, and Washington) and/or to integrate clinical and community services (Connecticut, Delaware, Idaho, Iowa, Michigan, New York, and Washington). For example, Michigan’s Community Health Innovation Regions will work with their Accountable Systems of Care and health care providers to identify local health needs and support integration between health and other community-based organizations.
- In addition, four Round 2 Model Test states (New York, Ohio, Tennessee, and Washington) have provider incentive payments and/or medical home qualifications based on prevention/population health measures.¹ For example, the Advanced Primary Care criteria New York practices have to meet to become Gate 3 practices

¹ While these incentive payments to providers are elements of the population health strategies, they are not directly attributable to the SIM program. SIM funds are not allowed to be used for incentive payments, to ensure voluntary participation and to avoid future sustainability issues.

and earn the highest enhanced payments include population health milestones. In Ohio, measures have to align with Ohio's population health priorities to be considered for the cross-payer alignment on PCMH quality metrics.

- To motivate participation in population health strategies, seven Round 2 Model Test states (Colorado, Connecticut, Idaho, Iowa, Michigan, New York, and Tennessee) are using grants or contracts to local public health agencies or community-based organizations as policy levers. For example, Iowa is awarding grants to Community Care Coalitions (C3s) to focus on either building coalitions or implementing population health improvement strategies. Idaho is contracting with the state's seven public health districts to establish and support Regional Health Collaboratives.

ES.6 Health Information Technology and Data Analytic Infrastructure

- Building health information technology (health IT) and data analytic infrastructure is a necessity for a range of delivery system and payment reforms in all Round 2 Model Test states' SIM Initiatives. The strategies for nearly all states for building health IT and data infrastructure involve quality measures—developing either a common set of core quality metrics (10 of 11 Model Test states—Colorado, Connecticut, Delaware, Idaho, Iowa, Michigan, New York, Ohio, Rhode Island, and Washington) and/or a Quality Reporting System (8 of 11 Model Test states—Connecticut, Delaware, Idaho, Michigan, New York, Ohio, Rhode Island, and Tennessee). For example, Delaware has developed a common scorecard—a set of 26 measures selected through a stakeholder consensus process—payers will use to support Delaware's payment reform models. Tennessee is developing a single, statewide portal for TennCare (the state's Medicaid program) providers to submit and receive required electronic health information, including data from the quality metric applications.
- Policy levers the Round 2 Model Test states are using to promote their SIM Initiative health IT and data analytic infrastructure strategies include grants for connecting to a statewide HIE, state legislation, delivery system certification, and contracts. Delaware is an example of a state that is using grants and state legislation. Through funding provided by the states, long-term care facilities can receive 2 years of no-cost, secure messaging and data extracts from the Long-Term Care Minimum Data Set and the Outcomes and Assessment Information Set. Delaware and Washington passed legislation that authorizes the administration and operation of all-payer claims databases (APCDs).

ES.7 Practice Transformation Facilitation and Workforce Development

- Ten of the 11 Round 2 Model Test states (Colorado, Connecticut, Delaware, Idaho, Michigan, New York, Ohio, Rhode Island, Tennessee, and Washington) are providing some form of technical assistance (TA) to primary care practices as a strategy to facilitate practice transformation. This TA varies across the 10 states. For example, Colorado provides practices with practice transformation coaches, who will work jointly with the practice to design improvement plans based on 10 milestones set by the state. Idaho offers practices a TA package tailored to their needs and priorities, which includes webinars, learning collaboratives, and individualized coaching.

- To help primary care physicians meet requirements of new delivery systems and payment models, six Round 2 Model Test states (Colorado, Connecticut, Idaho, and New York,) are developing, training, and hiring community health workers (CHWs) as part of their workforce development strategy. For example, Connecticut is developing protocols for CHW apprenticeships and identifying and filling potential CHW placements in primary care practices.
- Vendor contracts for practice transformation facilitation are a common policy lever used by states (6 of 11 Round 2 Model Test states—Connecticut, Delaware, Idaho, New York, Tennessee, and Washington). So that practices receive expert on-site and customized assistance that will enable them to participate in SIM strategies, states are using outside vendors to provide the practice transformation TA described in the first bullet. Four states (Colorado, Connecticut, Idaho, and Iowa) use grants as a policy lever. For example, Colorado’s SIM-funded small grants program provides funds practices can use to support the training and onboarding of clinical staff.

ES.8 Progress to Date

- At the time of the 2016 site visits, most Round 2 Model Test states (8 of 11 states—Colorado, Delaware, Idaho, Iowa, New York, Ohio, Tennessee, and Washington) were just a few months into the first year of the SIM Round 2 test period (Award Year 2).² However, four of those states had already launched some of their delivery systems and payment models in a small set of qualifying practices or a select region of the state. Colorado launched its primary care practice transformation with selection of the first 100 practices and its bidirectional health home models with four pilot community health mental centers. Idaho began its PCMH model with the first cohort of 55 practices. Tennessee implemented the first two (of five) waves of its EOCs. Washington started its Early Adopter of Medicaid Integration (Payment Model 1) in one region in southwest Washington and its Accountable Care Program (Payment Model 3) model in five counties.
- Progress to date suggests that leadership from the Governor’s Office can serve as a successful catalyst for convening stakeholders and identifying a plan for transformation of the state’s health care system. For example, many Ohio stakeholders cited the Governor’s Advisory Council and the state’s three SIM leadership design teams—multi-payer core, PCMH, and episode design teams—as important and helpful vehicles for convening key stakeholders, some of whom had not worked closely together before, to collaborate on transformation. The Governor of Idaho established the Idaho Healthcare Coalition, comprising key stakeholders from both the private and public sectors, to guide SIM implementation.
- Officials in three Round 2 Model Test states (Iowa, Ohio, and Rhode Island) noted that the SIM Initiative is facilitating better alignment across state agencies than had existed prior to the states’ SIM involvement. Separate agencies commonly oversee

² Since Connecticut, Michigan, and Rhode Island received no-cost extensions to their Award Year 1, they had not started their Award Year 2 at the time of the 2016 site visits or during the analysis period for this report.

medical care, public health, behavioral health, and long-term services and supports work without coordination models (such as the SIM Initiative).

ES.9 Challenges to Date

- Even as states noted the benefits of the Governor’s office in convening stakeholders, some states mentioned challenges that remain in leadership and collaboration:
 - **Work group challenges.** While most stakeholders were generally pleased with the selection process for work group members and impressed with the diverse stakeholder representation on each committee, they did have some work group challenges. For example, the Colorado work group shift from being directive to more focused on discussions of how to proceed was described as both an opportunity and a challenge. Work groups were able to self-direct actions and decisions, but the lack of high-level SIM leadership direction sometimes led to ambiguity.
 - **Insufficient Consideration of Stakeholder Feedback.** Some interviewees expressed the view that states were not sufficiently taking into account stakeholder feedback. In seven Round 2 Model Test states (Delaware, Colorado, Iowa, Ohio, New York, Rhode Island, and Tennessee), stakeholders perceived the state had predetermined priorities that prevented adequate incorporation of stakeholder feedback.
- The SIM Initiative is being implemented in an ever-changing dynamic environment (e.g., changes in state leadership, the state economy, health care programs). These changes take resources and time to manage and can lead to perceived or real conflict with SIM objectives and incentives, significantly impeding SIM progress:
 - **State structural deficit.** During the Connecticut site visit, nearly all state officials, as well as many other stakeholders, alluded to the state’s structural budget deficit as a major obstacle—affecting the ability of the state to fill SIM positions and jeopardizing participation by the state’s Medicaid program in some SIM-related activities.
 - **Medicaid payment model change.** The Iowa Medicaid program’s non-SIM related shift from fee for service to managed care has changed the state’s focus from transforming the health care system to the narrower goal of reducing Medicaid costs. This shift caused some beneficiaries to change their usual source of care and took control from the local level into the hands of national plans.
- Payer participation beyond Medicaid, as noted, will be necessary as states attempt to conform to the HHS Secretary’s directive to have 80 percent of the state’s population in an alternative payment model. However, payer engagement has been identified as a potential obstacle:
 - **Commercial payer resistance to change.** Six of the Round 2 Model Test states (Colorado, Connecticut, Idaho, New York, Rhode Island, and Washington) noted challenges engaging commercial payers in payment reform. These payers

generally support SIM goals, but would prefer to continue to set their own direction for provider payment.

- ***Need to engage Medicare.*** In seven of the Round 2 Model Test states (Colorado, Connecticut, Delaware, Idaho, New York, Ohio, and Tennessee), officials noted the need to engage Medicare in the SIM Initiative in order to reach the preponderance of care target for alternative payment methods.
- Securing provider participation in delivery system and payment reform models has also been challenging. Provider and stakeholder concerns include increased work load and risk with limited resources, insufficient incentive payments, a disconnect between performance and incentive payments, lack of payer commitment to SIM reforms, and lack of stakeholder communication and education.
- Recognizing the potential confusion and fatigue among both payers and providers from having to handle multiple efforts to transform health care, 10 of the Round 2 Model Test states (Colorado, Connecticut, Delaware, Idaho, Iowa, Michigan, New York, Ohio, Rhode Island, and Washington) are working to reduce provider burden by aligning the different sets of quality measures that each reform effort requires providers to report. However, the alignment process faces several challenges—including lack of data to produce the measures, diverse populations with varying health care needs, lack of appropriate attribution procedures, and alignment of the new measure sets with existing data collection and analytic systems.
- CMMI’s Funding Opportunity Announcement states that timely and efficient exchange of health information is central to effective implementation of the delivery system and payment reform models being tested under the SIM Initiative. Round 2 Model Test states are facing obstacles in setting up both statewide HIEs and APCDs:
 - ***Existing private sector solutions.*** One of the greatest challenges to any statewide health IT plan is the need to take account of existing private sector solutions. Even states with statewide HIEs said they are having trouble enlisting providers to use them, because providers see little value in joining the systems.
 - ***Differing stages of readiness and usefulness.*** The APCDs of the six Round 2 Model Test states (Colorado, Connecticut, New York, Rhode Island, Tennessee, and Washington) that are using them as a data source are at different stages of readiness for their designed purpose. Furthermore, the March 2016 Supreme Court ruling in *Gobeille v. Liberty Mutual Insurance Company* limited the usefulness of APCD data by concluding that states cannot require self-insured Employee Retirement Income Security Act plans to provide claims data to state APCDs.
- Stakeholders in nearly all Round 2 Model Test states noted shortages of health care providers and administrative staff. Workforce gaps were most often mentioned for primary care and behavioral health care providers, and in rural communities—which can complicate the collaboration needed for the new delivery systems.

ES.10 Statewide Changes in Health Care Expenditures and Utilization, Care Coordination, Quality of Care, and Population Health

This evaluation will quantitatively measure statewide changes in health and health care use, expenditures, coordination, and quality during the Award Years 2–4 of the Round 2 SIM Initiative. This report does not include quantitative analysis at such an early stage of SIM Round 2 implementation for two major reasons. First, the analysis period of this first annual report only goes through June 30, 2016, which includes 5 or fewer months of Award Year 2. Many reforms and efforts were not fully implemented by June 30, 2016. Second, data for Award Years 2–4 are not yet available to the evaluation team. Thus, this report discusses which strategies stakeholders think are likely to have the greatest impact on each of the statewide outcomes of interest, what stakeholders think success will look like with respect to each of the statewide outcomes, and how the Round 2 Model Test states will measure progress and success with respect to those statewide outcomes.

When discussing which SIM strategies stakeholders thought had the greatest potential of having an impact on health care utilization and expenditures and care coordination in their state, stakeholders did not generally assign relative priorities in likelihood of producing change. Stakeholders typically described all the SIM delivery system and payment reform models in their state as designed to increase the efficiency and value of the states' health care systems and to improve care coordination.

When asked which strategies would have the greatest impact on *quality of care*, however, stakeholders frequently mentioned performance requirements for delivery system certification and health outcome targets for incentive payment receipt. For example, Ohio stakeholders pointed to the quality metrics and financial incentives for providers in the state's PCMH and EOC initiatives. Washington stakeholders cited Payment Model 2, with its linking of gain sharing and risk to quality improvement under a population-based, pay-for-performance system for FQHCs and rural health clinics.

As the primary drivers of expected improvements in population health, stakeholders most often mentioned the models and strategies designed to integrate clinical, public health, and community-based services. For example, New York respondents said they expect Advanced Primary Care-certified practices that are aware of, and refer more of their patients to, community-based programs and social support services (e.g., supportive housing or addiction services) will lead to improved population health. Iowa respondents said they believe the state's C3s—community-based coalitions of health and social service stakeholders collaborating to promote care coordination by providing assessment and referrals to needed community and social services—are likely to impact population health.

While stakeholders said they recognize the potential of the models and strategies of the Round 2 Model Test states' SIM Initiatives to impact health and health care use, expenditures, coordination, and quality during the Award Years 2–4, they also said they realize no impacts are guaranteed, and they identified concerns about (and/or potential barriers to) the strategies being able to achieve an impact. In addition to those described under “Challenges to Date,” stakeholders repeatedly identified the following specific issues.

In four states (Iowa, Michigan, Rhode Island, and Washington) stakeholders mentioned the length of the test period—3 years. Washington providers expressed the need for restraint in expectations concerning the speed of implementation (and thus, impact)—with one provider reflecting that it will be a multiyear journey, and not something that can be achieved in 6 months. In Michigan, Iowa, and Rhode Island, stakeholders were skeptical that 3 years will be long enough to see significant changes in health and health care use, expenditures, coordination, and quality. In Iowa, stakeholders noted that some population health improvement activities may actually increase certain costs in the short run (e.g., doing more health screenings or providing more tobacco cessation treatments).

Like concerns about the length of the test period, stakeholders perceived sustainability as a barrier to eventually realizing changes from the strategies implemented as part of the SIM awards. Although 3 years may not be long enough to have a significant impact, the continuation of these strategies after Award Year 4 may lead to measurable results. However, there were concerns about the sustainability of parts of the SIM Initiatives in Idaho, Iowa, and Rhode Island. In Idaho, in particular, concern emerged among stakeholders that, without Medicare and self-funded employers participating, long-term funding may be inadequate to sustain care coordination activities. Sustainability was also noted as a concern for Iowa's care coordination efforts through its C3s—with stakeholders worried there will not be an ongoing funding source following Award Year 4. These stakeholders said they feel, further, that Iowa's decision to modify its care coordination plans to accommodate the introduction of Medicaid managed care, without considering its interaction with ACOs, may have led to implementation of Iowa's SIM care coordination efforts in a way that will not be useful for ACOs, and thus, not sustainable in the long run.

When discussing the potential for improved care coordination and behavioral health and primary care integration, stakeholders in Colorado, Connecticut, and Washington identified barriers to data sharing as a potential hindrance to success. Stakeholders in each of these states identified separate concerns related to coordination/integration—two of which involve regulation. In Colorado, multiple stakeholders mentioned the impact of *Code of Federal Regulations* 42 Part 2 as a regulatory barrier limiting data sharing for substance abuse data; as a result, Colorado's SIM Initiative is exploring strategies for obtaining client consent for sharing such data. A state official in Washington mentioned the Health Insurance Portability and

Accountability Act and its impact on data sharing, which most clearly affects the state's APCD. This official believed people will be less willing to try changes unless there is a federal policy or direction change. Connecticut's concern was not related to regulations, but rather to infrastructure. Stakeholders often described a state environment where providers—practices and institutions, as well as public agencies—are on different health IT platforms that create interoperability challenges.

ES.11 Conclusion

As Round 1 Model Design or Pre-Test states, the 11 Round 2 Model Test states developed designs and plans that provide detailed information on what innovative health care service delivery and payment models, policy levers, strategies, plans for integrating population health, and existing efforts they will include in their SIM Initiatives. Common elements across all 11 Model Test SIM Operational Plans include integration of primary care and behavioral health services, PCMHs, shared savings payment models, and quality measure alignment.

At the conclusion of this report's analysis period (June 30, 2016), most Round 2 Model Test states were only a few months into their Award Year 2. Stakeholders from all 11 Round 2 Model Test states expressed excitement over the potential for their SIM Initiatives to (1) accelerate statewide health care system transformation, with the aim of working toward having 80 percent of the state's population in an alternative payment model, as outlined by the HHS Secretary's directive; and (2) favorably impact health outcomes, health care use, expenditures, care coordination, and quality of care. At the same time, stakeholders in each state expressed skepticism and concerns related to potential barriers to success—including lack of participation by payers other than Medicaid, the relatively short SIM test period, provider shortages, lack of or limited data and data sharing, and stakeholder fatigue from participating in similar and often simultaneous reforms.

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1. Introduction, Organization, and Data and Methods

1.1 Overview of the State Innovation Model Round 2 and Evaluation

1.1.1 State Innovation Model Round 2

State governments have the potential to accelerate statewide health care system transformation. To test this potential, the Center for Medicare and Medicaid Innovation (CMMI) in 2015 awarded funds through the Round 2 State Innovation Model (SIM) Initiative to 11 Model Test states—Colorado, Connecticut, Delaware, Idaho, Iowa, Michigan, New York, Ohio, Rhode Island, Tennessee, and Washington. Model Test states are using policy and regulatory levers to enable or facilitate the spread of innovative health care models, integrating population health into transformation efforts, engaging a broad range of stakeholders, and leveraging existing efforts to improve health care delivery outcomes.

All 11 Round 2 Model Test states had been recipients of Round 1 Model Design or Pre-Test awards, in which they worked with CMMI to design State Health Care Innovation Plans, representing a state’s strategy “to use all of the levers available to it to transform its health care delivery system through multi-payer payment reform and other state-led initiatives.”³ These 11 states are the focus of this report.

The Model Test awards are for 4 years; Award Year 1 (pre-implementation period) was devoted to further development of implementation strategies as described in each Model Test state’s yearly Operational Plans. The next 3 Award Years comprise the test period during which the various strategies of the SIM Operational Plans are refined and implemented. For most states, the test period began February 1, 2016 and is scheduled to end January 31, 2019 (*Figure 1-1*). Three states received no-cost extensions to their Award Year 1—Rhode Island to June 30, 2016, resulting in a test period of July 1, 2016 through June 30, 2019; Michigan to July 31, 2016, resulting in a test period of August 1, 2016 through July 31, 2019; and Connecticut to September 27, 2016, resulting in a test period of September 28, 2016 through September 27, 2019.

³ Centers for Medicare & Medicaid Services. (2017). State Innovation Models initiative: General information. Retrieved from <https://innovation.cms.gov/initiatives/state-innovations/>.

Figure 1-1. Round 2 Model Test period of performance

Year	2015					2016					2017					2018					2019																											
Month	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D
Model Test States																																																
Colorado	Award Year 1					February 1, 2016					January 31, 2019																																					
Connecticut	Award Year 1					September 28, 2016					September 27, 2019																																					
Delaware	Award Year 1					February 1, 2016					January 31, 2019																																					
Idaho	Award Year 1					February 1, 2016					January 31, 2019																																					
Iowa	Award Year 1					February 1, 2016					January 31, 2019																																					
Michigan	Award Year 1					August 1, 2016					July 31, 2019																																					
New York	Award Year 1					February 1, 2016					January 31, 2019																																					
Ohio	Award Year 1					February 1, 2016					January 31, 2019																																					
Rhode Island	Award Year 1					July 1, 2016					June 30, 2019																																					
Tennessee	Award Year 1					February 1, 2016					January 31, 2019																																					
Washington	Award Year 1					February 1, 2016					January 31, 2019																																					

Source: Information provided by Center for Medicare and Medicaid Innovation (CMMI) on December 14, 2016.

Note: Cells shaded in pink represent months in which there is an intra-month (e.g., mid-month) transition between award years

1.1.2 Federal evaluation of State Innovation Model Round 2

CMMI contracted with the team of RTI International and its subcontractors—National Academy for State Health Policy, The Urban Institute, Mission Analytics, The Henne Group, Truven Health Analytics, and Native American Management Services Inc.—to conduct an independent, federal evaluation of the SIM Initiative Round 2. This report focuses on the Model Test states implementing their SIM Initiatives.

The RTI team evaluated how states fared obtaining a preponderance of care in value-based purchasing models and alternative payment models (APMs). In addition, the evaluation assessed the ability of the 11 Round 2 Model Test states to use levers to transform health care delivery and explores whether transformed health care delivery systems have an impact on quality of care, care coordination, health care utilization and expenditures, and population health. The overall impact of the SIM Initiative Round 2 will be assessed quantitatively using secondary data and qualitatively using information from document reviews, meeting participation, focus groups, and key stakeholder interviews.

1.1.3 Organization of the annual report

This first annual report of the SIM Round 2 evaluation contract analyzes data through June 30, 2016. In this report, the RTI team presents the results of the Year 1 site visits to the 11 Round 2 Model Test states, including stakeholder interviews and consumer and provider focus groups. The RTI team also collected data via ongoing review of state documents and from program and evaluation meetings with each state. Future annual reports will include quantitative data analyses, which were not available at this writing.

The remainder of this chapter (*Section 1.2*) provides a brief overview of the data and methods for conducting the site visits. Chapter 2 provides a cross-state summary of the models and strategies being implemented by the Round 2 Model Test states and the context in which

they are being implemented. Chapter 3 discusses the intended impacts of the SIM Initiatives and how states plan to measure these impacts. Chapter 4 provides brief summaries of each state's findings with respect to context, governance structure, stakeholder engagement, models and strategies, and expected outcomes. The RTI team reports expanded findings for each of the 11 Round 2 Model Test states in *Appendixes A through K*.

1.2 Overview of the Qualitative Evaluation

Evaluation teams for each state collected qualitative data throughout Year 1 of the SIM Round 2 evaluation. The evaluation team staff monitored state implementation activities through site visits, review of Model Test states' documents, and participation in monthly evaluation calls and state program calls with Model Test state SIM program staff. Site visit data collection included key informant interviews and provider and consumer focus groups. The data collected through these methods contain information about the Round 2 Model Test states through June 30, 2016. These data formed the basis for the high-level reports of findings for each Model Test state (see *Appendixes A through K*).

In its initial document reviews, the RTI team collected information about each Round 2 Model Test state from its Operational Plan, driver diagram, quarterly progress reports, and state profile prepared by the State Health Access Data Assistance Center. In addition, the evaluation team reviewed reports issued by the states' advisory committees or commissions. To supplement these documents, the RTI team collected information on states' SIM Initiatives or related initiatives from relevant news articles and reform-oriented web sites maintained by some of the states.

As a first step in analyzing the data from the site visits, the state evaluation teams reviewed, verified, and made any necessary edits to their key informant interview and focus group notes, referring to audio recordings as necessary. Using qualitative software, the evaluation team then grouped the site visit data into topical categories, based on the key themes that described the states' SIM Round 2 activities. Next, the RTI team used the software to generate reports by each theme for review and analysis. The evaluation team developed key themes using the discussion topics from the interview and focus group protocols, review of each state's documents (e.g., SIM meeting summaries and reports), and discussions with the state SIM teams. The RTI team synthesized the results into summaries of findings for each Model Test state and then performed a cross-state analysis. More details on the qualitative data collection are provided in *Appendix L*.

The RTI team also generated cross-state findings on implementation activities by reviewing the findings for each Round 2 Model Test state to determine commonalities. In addition, the team analyzed site visit and focus group data for all 11 Round 2 Model Test states together using NVivo software, based on key domains from the interview and focus group

guides. The evaluation team synthesized the information from both sources to summarize implementation activities. This summary was then combined with statistics that describe the health care context of the Round 2 Model Test states to produce the cross-state findings presented in *Chapter 2* and *Chapter 3* of this report.

1.2.1 Key informant interviews

The RTI team conducted on-site interviews with key informants in the SIM Round 2 Model Test states between April and June 2016. The key informant interviews focused on baseline data collection for pre-SIM implementation activities, intended SIM activities, SIM implementation, and the contexts of the state health care systems in which the SIM Initiatives are being implemented. Depending on type of respondent, discussion topics for the key informant interviews included progress on SIM implementation and operational activities, governance and project administration, stakeholder participation, health care delivery model reforms, payment system reforms, population health, health information technology (health IT) and other infrastructure investments, workforce development, outcomes and impacts, and technical assistance (TA) and other support resources.

Key interviewees included state officials, payers, providers, and consumer advocates. In five states, there was an “other” category to adequately capture key informants who did not align with one of the four predefined categories.⁴ The state evaluation teams conducted 201 interviews in all—16 to 21 interviews per state, for a state average of roughly 18 interviews.

Pairs of state evaluation team staff—one interviewer and one designated note taker—conducted key informant interviews during the site visits. The interview leaders used discussion guides to structure each interview session, and the note takers recorded the feedback from each session. Each interviewee was encouraged to share the feedback most relevant to their particular role in the SIM Initiative. RTI team interviewed key informants face to face whenever possible, but conducted the interviews via telephone when scheduling challenges prevented an in-person interview.

1.2.2 Focus groups

The qualitative research methods included focus groups with providers and consumers in each Round 2 Model Test state. The intent was to collect baseline information on consumers’ and providers’ perspectives on health care access, provider knowledge, patient health behavior, patient engagement, health IT, health care practice, care coordination, and the SIM Initiative.

The RTI team recruited focus group participants in each state from provider and consumer populations most likely to be impacted by the delivery system and payment models

⁴ Other key informants included research organizations, community representatives, and health IT-focused organizations.

being supported by that state's SIM Initiative. RTI's state evaluation teams used characteristics such as geographic location or place of residence, coverage type (e.g., Medicaid, state-employee plan), health conditions (i.e., physical and/or behavioral health diagnoses), practice participation in models, and medical specialty. The teams then matched these characteristics with those of the expected target consumers and providers of each state's SIM delivery system and payment models to develop a list of potential focus group participants.

The RTI team held focus groups in two to three locations in each state, choosing sites that had a sufficient concentration of the targeted populations from which to recruit participants. The evaluation team conducted a total of 22 provider and 22 consumer focus groups—two provider and two consumer focus groups per state. Four to 10 providers participated in each provider focus group, and 4 to 10 consumer patients participated in each consumer focus group. Most providers were primary care physicians and nurses; exceptions were focus groups in Connecticut (which also included addiction and mental health providers) and Ohio (which also included specialists). Consumer focus groups were mainly focused on Medicaid beneficiaries; exceptions included three focus groups—one in Delaware and two in New York—of state employees.

The focus group moderator used discussion guides to shape the dialogs, with evaluation team members contributing supplemental observations, note taking, and occasional questions.

1.2.3 State implementation activities

To gather additional information on state implementation of the models and strategies in their SIM awards, the RTI team collected and analyzed various other qualitative data. These data collections included (1) regularly participating in state check-in calls with the state's Centers for Medicare & Medicaid Services (CMS) project officer and SIM TA team, to hear states' planning and implementation progress updates; (2) reviewing state documents, including the states' quarterly and annual reports, Operational Plans, advisory committee and work group reports, and driver diagrams; and (3) searching reform-oriented Web sites maintained by some of the states.

The RTI team also held a monthly evaluation call with Round 2 Model Test states, except in Idaho, Michigan, and Tennessee, where discussions occurred during regular program management calls between states and their cognizant project officers. During these monthly evaluation calls, the evaluation team discussed the data and materials needed for the federal evaluation and gathered information about state implementation and state evaluation activities, including successes, challenges, and lessons learned.

1.3 Limitations

There are a few limitations that should be noted when reviewing this report. First, the SIM Initiative and its implementation are very dynamic. Thus, at the reading of this report, many of the analysis results and initiative designs and progress may have changed from their state at the

end of the analysis period of this report, June 30, 2016. It will be important for the reader to remain cognizant of this fact. This report is an interim assessment of the SIM Initiative and is the first in a series of four annual reports and a final report.

A major data source for this report is the responses that the RTI team collected during its site visit interviews and focus groups. Although the goal of the interviews and focus groups was to obtain feedback (including viewpoints) from a variety of stakeholders, there is no guarantee that the individuals who participated in the interviews and focus groups were representative of the actual populations in the Model Test states. Therefore, the analysis results from the qualitative data may be skewed. Furthermore, the accuracy of the responses received from the respondents cannot be guaranteed. For example, there were instances in which respondents requested initiative changes that CMMI was restricted from being able to provide.

As previously mentioned, this report does not contain any analysis of quantitative data associated with expected outcomes from the SIM Initiative. The timing of the preparation of this report and the availability of data prevented the inclusion of baseline and initiative period data. However, as data become available, they will be included in future annual reports.

2. Implementation Activities Summary

Through the SIM Initiative, the Round 2 Model Test states are aiming to improve health care performance and the health of state residents, while lowering the level or growth of health care costs. Connecticut, Idaho, and Tennessee also aim to improve health equity and access to care, under their SIM awards. However, the approaches states are taking to achieve these goals vary markedly.

All Model Test states are promoting or supporting adoption of delivery system or payment models designed to strengthen primary care and/or coordinate services among different providers. The extent to which SIM funds directly support the development, spread, or operation of these models—versus that of strategies such as investment in health information technology (health IT) and data analytic infrastructure and/or workforce development that enable these models to perform as expected—varies considerably. The SIM awards in some states, such as Ohio, are focused entirely on delivery system and payment models, whereas other states, such as Rhode Island, are focused almost entirely on enabling strategies. These variations in the states' emphasis on models and enabling strategies arise from the different health care landscapes in which the SIM Initiatives are being implemented.

2.1 Context of Health Care System: Variation Among States

The 11 Round 2 Model Test states vary along a number of dimensions that affect the states' readiness and ability to accelerate the transformation of their health care systems to meet the United States Department of Health and Human Services (HHS) Secretary's goal of having 80 percent of the state's population (i.e., preponderance of care) in an APM—including state population characteristics, delivery system, numbers and types of providers, health insurance market, and state involvement in other health care transformation efforts. A cross-state summary of significant characteristics noted by stakeholders during the first set of site visits follows.

2.1.1 Characteristics of the state populations, health care systems, and insurance markets

Population size and geography. The Round 2 Model Test states range in population size from the seventh and ninth smallest states (Delaware at 959,100 residents and Rhode Island at 1,044,800 residents in 2015) to the fourth largest (New York, with almost 20 million residents in 2015). All residents of Delaware and Rhode Island live in metropolitan areas, whereas Iowa (40 percent), Idaho (35 percent), Ohio (24 percent), Tennessee (18 percent), Colorado (16 percent), Michigan (13 percent), and Washington (14 percent) all have substantial percentages of residents residing in nonmetropolitan areas.⁵ Stakeholders in Delaware, Ohio, New York, and Tennessee

⁵ Henry J. Kaiser Family Foundation. (2016). *State health facts*. Retrieved October 3, 2016. Available at <http://www.statehealthfacts.org>

noted that health care transformation in the rural areas of their states faces different challenges, requires different supports, and will take different forms for these geography-based differences. One approach will not work for all areas within these states.

Insurance coverage type. *Table 2-1* shows the insurance coverage of the Round 2 Model Test states by coverage type in 2014. A preponderance of care will require adoption of payment reform in not only Medicaid, but also a substantial number of commercial plans and Medicare. About half the population is covered by employer-sponsored insurance in all the states, ranging from 48.8 percent in Tennessee to 56 percent in Delaware. Medicare covers the next largest share, ranging from 13.8 percent in Colorado to 18.1 percent in Michigan. These payers are followed by Medicaid and the Children’s Health Insurance Program (CHIP), which together cover between 10.9 percent of the population in Idaho and 18.8 percent in New York. In 2014, a significant percentage of the population remained uninsured in all 11 states, ranging from 5.7 percent in Iowa to 13.3 percent in Idaho; two Round 2 Model Test states (Idaho and Tennessee) had uninsured rates higher than the national average.

Table 2-1. State Innovation Model Round 2 Model Test states’ insurance coverage by type and percentage of population, 2014

State	Employer	Individual	Medicaid/CHIP	Medicare	Uninsured
United States	51.2%	6.4%	14.6%	16.2%	11.6%
Colorado	54.1%	8.2%	13.4%	13.8%	10.4%
Connecticut	55.4%	6.2%	15.1%	16.4%	6.9%
Delaware	56.0%	4.0%	14.7%	18.0%	7.3%
Idaho	49.7%	9.9%	10.9%	16.1%	13.3%
Iowa	56.6%	8.0%	12.5%	17.2%	5.7%
Michigan	52.9%	5.7%	14.8%	18.1%	8.4%
New York	51.3%	5.3%	18.8%	16.0%	8.6%
Ohio	54.6%	4.6%	15.1%	17.3%	8.3%
Rhode Island	52.8%	6.3%	16.2%	17.6%	7.0%
Tennessee	48.8%	6.6%	15.1%	17.6%	11.8%
Washington	54.4%	6.8%	14.0%	15.6%	9.1%

Source: State Health Access Data Assistance Center.⁶

CHIP = Children’s Health Insurance Program.

Note: Employer coverage includes military and Veterans Administration coverage, which represents less than 2 percent of the national population.

⁶ State Health Access Data Assistance Center. Analysis of American Community Survey (ACS) Public Use Microdata Sample (PUMS) files. University of Minnesota. *State Health Compare*. Retrieved from <http://statehealthcompare.shadac.org/map/11/health-insurance-coverage-type-by-total#1/7/21>.

Medicaid expansion and individual insurance marketplace. States' decisions related to the Affordable Care Act's (ACA's) Medicaid expansion and the individual insurance marketplace also could affect the effectiveness of policy levers available to states to promote health care transformation. All SIM Round 2 Model Test states are using their role as purchaser for Medicaid to be a first mover to promote health care transformation under the SIM Initiative—a lever that will have a larger effect as the Medicaid enrolled population increases. All Round 2 Model Test states, except Idaho and Tennessee, have expanded Medicaid under the ACA authority. Furthermore, states that establish their own marketplace realize higher Medicaid enrollment than states using the federally facilitated marketplace (FFM). In states that use the FFM, Medicaid enrollment is higher when the states have the FFM determine eligibility, rather than just assess and refer potential enrollees to the states' Medicaid programs.⁷

Table 2-2 shows the Round 2 Model Test state decisions with respect to the ACA Medicaid expansion and individual marketplace. Six states (Colorado, Connecticut, Idaho, New York, Rhode Island, and Washington) established their own marketplaces. Among the states using the FFM, only Tennessee has the marketplace determine Medicaid eligibility.

Insurance market concentration. The competitiveness of the health insurance market is another key characteristic that stakeholders noted as possibly impacting the progress and form of the SIM Initiative Round 2 models and strategies. In a highly concentrated market, fewer entities need to be brought to the table, and the critical mass needed to make change happen may be easier to achieve. Furthermore, with fewer involved entities, data analytics and alignment of quality measures and payment models may be more feasible. Five states (Delaware, Idaho, Iowa, Rhode Island, and Tennessee) have concentrated commercial insurance markets, with a dominant carrier holding shares of two-thirds or more of the market (**Table 2-3**).

In contrast, other Round 2 Model Test states have more competitive insurance markets. Michigan and Ohio have several commercial insurers with modest market shares. Therefore, getting enough cooperation to make significant progress toward a preponderance of care may require more time and resources in these two states than in states with one or a few dominant commercial insurers. New York also has many insurance carriers; New York officials commented that although many of the state's payers have been engaged in the SIM Initiative, having to deal with so many has slowed implementation and is likely to continue to do so as the SIM Initiative unfolds.

⁷ Rosenbaum, S., Schmucker, S., Rothenberg, S., & Gunsalus, R. (2014, March). Streamlining Medicaid enrollment: The role of the Health Insurance Marketplace and the impact of state policies. *The Commonwealth Fund*. Retrieved September 19, 2016, from <http://www.commonwealthfund.org/publications/issue-briefs/2016/mar/medicaid-enrollment-marketplaces>.

Table 2-2. State Innovation Model Initiative Round 2 Model Test states' Affordable Care Act Medicaid expansion and individual marketplace decisions, January 2016

State	Medicaid expansion decision (as of July 2016)	Medicaid/CHIP income eligibility as % of the FPL (as of January 2016)			Individual marketplace decision (as of January 2016)	
		Children aged 1–18 years (upper income limit)	Parents	Other adults	Type of marketplace	FFM assists in Medicaid/CHIP eligibility decision ^a
Colorado	Expanded	265%	138%	138%	State	N/A
Connecticut	Expanded	323%	155%	138%	State	N/A
Delaware	Expanded	217%	138%	138%	Partnership	Assessment
Idaho	Not expanded	190%	26%	0%	State	N/A
Iowa	Expanded	380%	138%	138%	FFM	Assessment
Michigan	Expanded	217%	138%	138%	Partnership	Assessment
New York	Expanded	405%	138%	138%	State	N/A
Ohio	Expanded	211%	138%	138%	FFM	Assessment
Rhode Island	Expanded	266%	138%	138%	State	N/A
Tennessee	Not expanded	255%	101%	0%	FFM	Determination
Washington	Expanded	317%	138%	138%	State	N/A

Source: Henry J. Kaiser Family Foundation (2016).⁸

^a FFM conducts assessment or final determination for Medicaid eligibility.

CHIP = Children's Health Insurance Program; FFM = federally facilitated marketplace; FPL = federal poverty level; N/A = not applicable.

⁸ Henry J. Kaiser Family Foundation. (2016). *State health facts*. Retrieved October 3, 2016, from <http://www.statehealthfacts.org>

Table 2-3. State Innovation Model Initiative Round 2 Model Test states: Number of credible insurance carriers, name and market share of largest carrier, 2014

State	Small group		Large group		Individual	
	Number of credible insurance carriers	Largest carrier (market share)	Number of credible insurance carriers	Largest carrier (market share)	Number of credible insurance carriers	Largest carrier (market share)
Colorado	11	Rocky Mountain Hospital & Medical Service, Inc. (26.5%)	16	Kaiser Foundation Health Plan of Colorado (46.2%)	14	Kaiser Foundation Health Plan of Colorado (25.2%)
Connecticut	6	ConnectiCare Insurance Co., Inc. (37.5%)	11	Anthem Health Plans, Inc. (32.9%)	7	Anthem Health Plans, Inc. (37.6%)
Delaware	4	Highmark BCBS Delaware, Inc. (62.5%)	7	Highmark BCBS Delaware, Inc. (70.3%)	3	Highmark BCBS Delaware, Inc. (79.2%)
Idaho	5	Blue Cross of Idaho Health Service, Inc. (52.8%)	7	Blue Cross of Idaho Health Service, Inc. (68.7%)	5	Blue Cross of Idaho Health Service, Inc. (64.8%)
Iowa	8	Wellmark, Inc. (61.9%)	10	Wellmark, Inc. (66.7%)	5	Wellmark, Inc. (70.7%)
Michigan	21	BCBS of Michigan Mutual Insurance Co. (35.0%)	24	BCBS of Michigan Mutual Insurance Co. (32.9%)	18	BCBS of Michigan Mutual Insurance Co. (35.9%)
New York	21	Oxford Health Insurance, Inc. (30.9%)	22	Excellus Health Plan, Inc. (18.5%)	15	Health Republic Insurance of New York, Corp. (26.2%) ^a
Ohio	22	Community Insurance Co. (36.5%)	20	Community Insurance Co. (41.2%)	16	Medical Mutual of Ohio (28.3%)
Rhode Island	3	BCBS of Rhode Island (79.0%)	5	BCBS of Rhode Island (77.3%)	1	BCBS of Rhode Island (97.5%)
Tennessee	9	BCBS of Tennessee, Inc. (65.8%)	11	BCBS of Tennessee, Inc. (77.0%)	10	BCBS of Tennessee, Inc. (63.9%)
Washington	9	Premera Blue Cross (50.1%)	17	Premera Blue Cross (29.4%)	13	Premera Blue Cross (26.7%)

Source: National Association of Insurance Commissioners.⁹

^a Health Republic was shut down by the New York State Department of Financial Services because of poor financials in 2015.

BCBS = Blue Cross Blue Shield.

Note: Credible insurance carriers include active insurers that have at least 1,000 covered lives and positive premium earnings.

⁹ National Association of Insurance Commissioner, *2014 Supplemental Health Care Exhibit Report*, Volume 1, 2015. Available at National Association of Insurance Commissioners. (2016). *2015 Supplemental health care exhibit report: Volume 1*. Retrieved October 4, 2016, from http://www.naic.org/documents/prod_serv_statistical_hcs_zb.pdf.

Managed care. The penetration of managed care, particularly in Medicaid and Medicare, also can impact the progress and final form of the models and strategies states adopt. Managed care in public programs adds a layer of contracting between the government and providers. Historically, managed care organizations (MCOs) determine the payment types and amounts for providers in their networks. To effectively influence contracts between the MCOs and providers, state governments may need to exercise their levers of renegotiating government’s contracts with the MCOs. **Table 2-4** shows that the percentage of enrollees under comprehensive managed care plans ranges from zero (Connecticut and Idaho) to 100 percent (Tennessee) in the Round 2 Model Test states’ Medicaid programs, and from 8 percent (Delaware) to 38 percent (Ohio) in their Medicare Advantage plans. The number of MCOs contracting for these populations in each state also varies widely.

Table 2-4. State Innovation Model Initiative Round 2 Model Test states managed care penetration, Medicaid and Medicare Advantage plans, 2015

State	Managed care penetration (percentage total enrolled population)		Managed care contracts	
	Medicaid (as of July 2015)	Medicare Advantage (as of 2015)	Medicaid (as of March 2016)	Medicare Advantage (as of 2015)
Colorado	9% ^a	37%	2	12
Connecticut	N/A	25%	N/A	9
Delaware	90%	8%	2	4
Idaho	N/A	32%	N/A	11
Iowa	12%	14%	3	14
Michigan	77%	32%	11	19
New York	78%	37%	25	44
Ohio	78%	38%	5	25
Rhode Island	88%	35%	2	3
Tennessee	100%	34%	4	12
Washington	79%	30%	5	21

Source: Henry J. Kaiser Family Foundation (2016).¹⁰

^a The managed care penetration for Colorado does not include the 65 percent of Colorado Medicaid beneficiaries enrolled in Primary Care Case Management.

N/A = not applicable; these states do not offer managed care plans to their Medicaid beneficiaries.

¹⁰ Henry J. Kaiser Family Foundation. (2016). *State health facts*. Retrieved October 3, 2016, from <http://www.statehealthfacts.org>.

Integration of primary care and behavioral health services. Integration of primary care and behavioral health services are part of all Round 2 Model Test states’ SIM Operational Plans and a key focus of the Colorado, Rhode Island, and Washington SIM Operational Plans. However, Medicaid managed care plans frequently carve out these services—that is, the plans contract for these services separately, often to different organizations, thus possibly complicating or preventing integration. As of July 2015, Tennessee was the only Round 2 Model Test state that included all behavioral health services in its MCO contracts for all Medicaid beneficiaries (*Table 2-5*).

Table 2-5. State Innovation Model Initiative Round 2 Model Test states’ coverage of behavioral health services under Medicaid managed care contracts, July 2015

State	Outpatient mental health	Inpatient mental health	Substance abuse
Colorado	Carved-out	Carved-out	Carved-out
Connecticut	N/A	N/A	N/A
Delaware	Varies (services)	Varies (services)	Varies (services)
Idaho	N/A	N/A	N/A
Iowa	Carved-out	Carved-out	Carved-out
Michigan	Varies (services)	Varies (services)	Carved-out
New York	Varies (population, services)	Varies (population, services)	Varies (services)
Ohio	Varies (population)	Carved-in	Varies (population)
Rhode Island	Varies (services)	Varies (services)	Varies (services)
Tennessee	Carved-in	Carved-in	Carved-in
Washington	Carved-out	Carved-out	Carved-out

Source: Smith et al. (2015).¹¹

N/A = not applicable

Note: Carved-in means states include coverage of nearly all behavioral health services (exceptions might relate to small carve-outs for select drugs, etc.) in their Medicaid managed care contracts. Varies refers to states that carve-in services for only some populations covered under MCOs or only some services (e.g., more intensive services may be carved-out). Carved-out means services are mostly not covered by managed care and are covered by fee for service or Physicians Health Plans.

¹¹ Smith, V. K., Gifford, K., Ellis, E., Rudowitz, R., Snyder, L., & Hinton, E. (2015, October). Medicaid reforms to expand coverage, control costs, and improve care: Results from a 50-state Medicaid budget survey for state fiscal years 2015 and 2016. Report prepared for the Henry J. Kaiser Family Foundation and the National Association of Medicaid Directors. Retrieved October 4, 2016, from <http://files.kff.org/attachment/report-medicare-reforms-to-expand-coverage-control-costs-and-improve-care-results-from-a-50-state-medicare-budget-survey-for-state-fiscal-years-2015-and-2016>.

2.1.2 Prior and ongoing health care delivery system and payment reform in the states

All SIM Round 2 Model Test states had SIM Round 1 Model Design or Model Pre-Test awards. At least seven (Colorado, Connecticut, Idaho, Iowa, Michigan, New York, and Rhode Island) have established patient-centered medical homes (PCMHs) in their Medicaid/CHIP programs, and four of these states (Colorado, Iowa, New York, and Rhode Island) have established accountable care organizations (ACOs) within their Medicaid programs.

States are building on existing reforms for the SIM Initiative. PCMH reform activities pre-dating SIM in seven states are summarized here, along with their relationship to the respective state's award:

- Colorado's Medicaid primary care case management program, Accountable Care Collaborative, launched in 2011. Through the Accountable Care Collaborative, primary care medical providers contract with seven regional care collaborative organizations to provide medical home services to Medicaid enrollees. Individuals with behavioral health issues also are served by behavioral health organizations. In addition, Colorado is trying to align some changes in the proposed Regional Accountability Entity—a single body that will take over the patient onboarding, data, finance, and other delivery system operations previously run by regional care collaborative organizations and behavioral health organizations separately—with its SIM Initiative.
- Connecticut's prior Medicaid PCMH program will serve as the basis for several key health care reforms under the SIM Initiative, including the Advanced Medical Home program and the Person Centered Medical Home Plus (PCMH+) Program.¹² In addition, the state's Health Enhancement Program—a value-based insurance program that offers reduced monthly premiums and lower cost-sharing for state employees who commit to receive certain preventive care—will serve as an important building block for the multi-payer value-based insurance design (VBID) initiative under the SIM Initiative.
- In 2009, Idaho received a grant from the Commonwealth Fund focused on transforming safety-net primary care clinics into PCMHs. In 2010, through Executive Order, the Governor created the Idaho Medical Home Collaborative to pilot and test the feasibility of a multi-payer PCMH model within the state. From 2010 to 2014, Idaho secured additional support from the Commonwealth Fund, the Agency for Healthcare Research and Quality (AHRQ), and others to continue these efforts, which have since merged and expanded with the SIM Initiative. Through the SIM Initiative, Idaho is working to expand the number of PCMH primary care practices beyond those that participated in the pilot, and expand all services offered through the pilot to all patients, not just those with chronic conditions. The success of these previous

¹² During the reporting period (February 1, 2015–June 30, 2016), PCMH+ was known as Medicaid Quality Improvement Shared Savings Program (MQISSP). The information regarding PCMH+ included in this report relate to program details and stakeholder understanding of MQISSP.

initiatives helped form the state's PCMH model being implemented under the SIM Initiative.

- Iowa's Community Care Coalitions (C3s), which are the primary mechanism for promoting and effecting community-based change under its SIM Initiative, are a continuation of the Community Care Team Pilot launched in 2014. The pilot, which funded six community care teams, was implemented by the Iowa Primary Care Association with financing from the Iowa state legislature.
- In Michigan, the medical home model was explored under several efforts. The Michigan Primary Care Transformation demonstration project, an important building block for that state's SIM Initiative, is a multi-payer demonstration that tested payment reform models and expanded PCMH capacity throughout the state. The Michigan Children's Health Access Program is a pediatric medical home demonstration, and Blue Cross Blue Shield's (BCBS') Physician Group Incentive Program is a medical home transformation program that has been operating in the state for over a decade.
- In developing its approach to certifying practices as medical homes and recruiting payers to make new payments to these practices, as part of New York's Advanced Primary Care (APC) model, New York used lessons learned from the multi-payer Adirondack Medical Home Demonstration—which eventually included Medicare as part of CMS's Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration—and the multi-payer initiative in the Capital District-Hudson Valley Region—which also included Medicare through CMS's Comprehensive Primary Care initiative (CPCi). In addition, New York drew on previous efforts to incentivize primary care practices to obtain National Committee for Quality Assurance PCMH certification through payments available from Medicaid to guide the development of the APC model.
- In 2008, Rhode Island implemented one of the first multi-payer PCMH initiatives in the country: the Chronic Care Sustainability Initiative, now titled the Care Transformation Collaborative. As of spring 2016, the state's PCMH initiative included 73 practice sites and 430 primary care providers and served over 300,000 patients, mostly adults. The Rhode Island SIM Initiative is expanding the model to the pediatric population.

The Round 2 Model Test states also participate in several federally funded health care reform demonstrations and initiatives. *Appendix Table M-1* shows the different state, private, and federal health care transformation initiatives in which each Round 2 Model Test state has been involved to date. Many of these health care transformation initiatives are running concurrently with the SIM Initiative.

- All 11 states participated, currently participate, or will participate in one or more CMMI primary care transformation initiatives—such as MAPCP, CPCi, Comprehensive Primary Care Plus (CPC+), and the Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration.

- All also have participated in the CMMI Bundled Payments for Care Improvement Initiative and the CMS Transforming Clinical Practice Initiative (TCPI), and have one or more Health Care Innovation Awards.
- All except Idaho and Washington also participate in at least one Medicare ACO program.
- Colorado, Michigan, New York, Ohio, Rhode Island, and Washington participate in the Financial Alignment Initiative.

2.2 Governance and Project Administration

2.2.1 State Innovation Model Initiative leadership

State offices and agencies. The SIM Initiative is being led out of various state government offices and agencies, including the Governor’s Office (Colorado); the state’s department of health (New York),¹³ health and human services (Michigan), the state’s Medicaid authority (Iowa), the state’s health insurance commission (Rhode Island), and special departments or offices of health care transformation (Connecticut, Delaware, Idaho, Ohio, and Tennessee). In Washington, SIM is administered by an agency that is both the Medicaid authority and purchaser of coverage for public employees.

Other state agencies are included in the administrative structure to oversee SIM activities in their area of authority. For example, state departments of public health have operational responsibility for models and strategies related to the population health goals of the state’s SIM Initiative. The Colorado Department of Public Health and Environment acts as the bridge for local public health agency (LPHA) engagement and technical support given to practices participating in the SIM Initiative. The SIM-related efforts of the Idaho Department of Health and Welfare’s Division of Public Health are focused on assisting the Regional Health Collaboratives (RCs) in supporting practice transformation to the PCMH model and integrating the PCMHs into the broader medical-health neighborhood.

Furthermore, because all Round 2 Model Test states are using their authority as purchasers for the Medicaid program as a key policy lever, all states’ agencies that oversee Medicaid are part of the SIM leadership team. Some states, such as Colorado and Ohio, have formal SIM leadership structures comprising senior staff from multiple state agencies, including those that oversee Medicaid. In Colorado, the Department of Health Care Policy and Financing (which houses the Medicaid agency), the Department of Public Health and Environment, and the Office of Behavioral Health within the Department of Human Services, have representation on the SIM Advisory Board and share operational responsibilities for the state’s SIM Initiative.

¹³ New York State created a new office within its Department of Health, called the Division of Health Care Innovation, which is leading the state’s SIM effort. This office is staffed by state employees as well as individuals employed by Health Research, Inc., who are embedded within this office.

Ohio's SIM leadership is organized through the SIM Directors Group, which includes leaders of the Office of Health Transformation, Department of Medicaid, Department of Health, Department of Mental Health and Addiction Services, and Department of Administrative Services (which is responsible for state employee health plans).

Consultants and contractors. Many states supplement the state SIM administrative staff with various consultants and contractors. For example, in Delaware, McKinsey & Company (McKinsey) supported project staff functions during this report's analysis period—including project management, committee support, common scorecard development, and payment model design. However, the consultants' role is expected to diminish over time, as state agency staff and staff from the Delaware Center for Health Innovation (DCHI) begin to assume more of these responsibilities.

Tennessee is another example of a state that uses contractors. Tennessee contracts with various state-based organizations to supplement state staff, including the Tennessee Medical Association to conduct outreach to physicians, the Tennessee Chapter of the American Academy of Pediatrics to assist physician offices in conducting quality improvement projects, and the five Schools of Public Health in the state to develop regional, population health improvement plans. Tennessee, as well as Ohio, is using McKinsey to complete analyses related to the episode of care (EOC) and PCMH models.

Contractors also support Rhode Island SIM staff. Rhode Island contracts with the University of Massachusetts Medical School—and subcontractors The Providence Plan and the Technical Assistance Center—to assist with project management, writing the population health plan, and supporting measure alignment.

2.2.2 Stakeholder engagement

The SIM Initiative depends on public and private engagement. The chief means the Round 2 Model Test states have used to engage private stakeholders is through committee and work group membership. Committees and work groups provide an opportunity for a diverse array of stakeholders to voice their opinions and concerns over specific elements of the plan and provide input and guidance to the state.

Most Round 2 Model Test states have a steering committee or advisory council, whose membership includes representatives from participating public agencies and major private payers, providers, consumer advocates, employers, and other key stakeholders in the state. These entities guide all aspects of SIM implementation. States also typically have three to nine multi-stakeholder committees or work groups focused on the development and implementation of specific aspects of the SIM Initiative. For example, seven states (Colorado, Connecticut, Delaware, Idaho, Michigan, Rhode Island, and Washington) have a work group specifically on

population health activities. Other common work groups include practice transformation, payment reform, workforce development, health IT, and consumer engagement.

The 11 states use different approaches to identify work group members. In Colorado and Connecticut, work group members were chosen through a competitive application process. Other states reached out to selected stakeholders to engage them in the process. Ohio had an existing Governor's Council comprising purchasers, plans, providers, consumers, and researchers that met periodically to advise the state on priorities for, and coordination of, multi-payer health care reform activities statewide. This council also recommended experts to participate on SIM-related committees. In Rhode Island, the Secretary of the Executive Office of Health and Human Services invited stakeholder groups to participate in development of its model design plan, Rhode Island State Healthcare Innovation Plan: Better Health, Better Care, Lower Cost. Many of these stakeholders were then chosen to serve on the 30-member Model Test Steering Committee that helped shape the state's Model Test Operational Plan. In Tennessee, medical associations were asked to submit names of suggested providers for participation in the Technical Advisory Groups for the EOC and PCMH models.

Beyond advisory committees and work groups, the Round 2 Model Test states are engaging and educating stakeholders through public meetings and symposia, targeted public listening forums, ad-hoc meetings and presentations, newsletters, and documents posted on SIM Web sites for public comment.

2.2.3 Decision-making process

All states defined the decision-making process for the SIM Initiative as a collaboration with payers, providers, public health and community leaders, and consumers across the state. The intent is to develop partnerships across sectors and communities to support system change. Although in all states the ultimate decision-making authority for the SIM Initiative remains with state officials, Delaware, Idaho, and Rhode Island use a modified consensus model to reach decisions. Delaware state officials characterized their use of the consensus model as not leading through "mandating or legislating," but rather through a stakeholder consensus process led by public and private entities.

2.2.4 Funding

Officials from the Round 2 Model Test states gave varied responses to the question on the adequacy of SIM funding. Rhode Island officials noted that CMS provided award that was less than the state's proposed SIM budget (by two-thirds in each case), which required significant reductions in the scope of the SIM Initiative, possibly limiting its ultimate impact. Rhode Island stakeholders reported that their award being smaller than requested resulted in the removal of a patient portal and electronic health record (EHR) incentive program for behavioral health and long-term care community providers, scaling back some of the child health initiatives

(such as PCMH Kids and the Child Psychiatry Access Program), and scope reduction of patient engagement activities.

Several state officials noted that implementation of the SIM Initiative relies on volunteers, and many stakeholders from public and private sectors are devoting resources to implement the SIM Initiative models and strategies. For example, Delaware’s total budget for efforts related to the SIM Initiative is \$130 million, only \$35 million is from the SIM award from CMS; the remaining \$95 million comes from stakeholder contributions.

Providers and payers repeatedly expressed how the SIM Initiative has created a significant strain on internal resources—including the time needed to attend stakeholder and work group meetings, develop internal systems for the delivery system and payment models, and provide education and training for providers and consumers.

To make up for the differences between their awards and proposed SIM budgets, states are leveraging other sources to fund some components of their SIM Initiatives and dropping other components. For example, to enable funding for the Healthy Neighborhood Model, Delaware aligned that model with public health initiatives, such as the State Health Improvement Plan. To help accelerate and sustain the impact of its Accountable Communities of Health (ACHs), Washington is hoping to use a Medicaid transformation waiver which was under CMS review during the analysis period of this report. Rhode Island is leveraging a federal Substance Abuse and Mental Health Services Administration grant to support its SIM-related Screening, Brief Intervention, and Referral to Treatment project, but had to forgo a patient portal and an EHR incentive program for behavioral health and long-term services and supports (LTSS) community providers from the scope of its SIM Initiative.

2.3 Delivery Systems and Payment Reforms

2.3.1 Strategies

Under the SIM Initiative, all Round 2 Model Test states are establishing or expanding one or more delivery system and/or payment reform models (*Tables 2-6a* and *2-6b*).

Primary care transformation. Seven Round 2 Model Test states are targeting primary care providers for participation in a PCMH or other practice transformation models focusing on care coordination. The other four states are focusing on payment reform for primary care providers (Colorado, Delaware) or all providers (Iowa, Washington), regardless of the delivery system model in which the practices participate. The target population for these delivery system models is typically all patients of participating practices.

Table 2-6a. State Innovation Model Initiative Round 2 Model Test states' health care delivery system models

Delivery system model	CO	CT	DE	ID	IA	MI	NY	OH	RI	TN	WA
Primary care medical homes		X		X		X	X	X	X	X	
Health homes for medically complex	X									X	
Accountable care		X				X					X
Behavioral health integration	X	X	X						X	X	X
Other models	X		X								

X = delivery system model is included in state's SIM Initiative plans

Table 2-6b. State Innovation Model Initiative Round 2 Model Test states' health care payment reform models

Payment reform models	CO	CT	DE	ID	IA	MI	NY	OH	RI	TN	WA
Episode of care								X		X	
PMPM payments tied to performance		X		Medicaid				All in PCMH	PCMH Kids		
Upside shared savings		All				X		All in PCMH		Health Link, Medicaid low-volume PCMH	Medicaid Early Adopter & PEBB
Upside and downside shared savings							X	All in EOC		All in EOC	ACN
Total cost of care			X							Medicaid high-volume PCMH	
Allows payer choice			All	Commer- cial	Medicaid MCO		All				
Other models							X			(a)	
Not specified; under development	All					Medicaid					Medicaid FQHC/ RHC

ACN = Accountable Care Networks in Washington; All = all participating payers (typically Medicaid and commercial insurers); Commercial = participating commercial insurers; Early Adopter = payment reform model in Washington that integrates Medicaid purchasing of physical health services with mental health and substance abuse services; EOC = episode of care payment model; FQHC = Federally Qualified Health Center; MCO = managed care organization; PCMH = patient-centered medical home model; PEBB = Public Employee Benefits Board (state employees in Washington); PMPM = per member per month; RHC = rural health clinic; X = payment reform model is included in state's SIM Initiative plans with no further details.

^a Tennessee is adopting different VBP models for long-term services and supports (LTSS), including quality-based retrospective rate adjustment for nursing homes and per diem quality-based bonus payments for extended respiratory care providers.

Few payers outside Medicaid have currently committed to the payment reforms of these models, however. All 11 states' Medicaid programs participate, serving as first mover to motivate other payers. Two states (Michigan and Tennessee) are focusing their SIM efforts exclusively on transforming practices serving Medicaid beneficiaries. Delaware and Ohio also are targeting state employee plans. Participation of other commercial plans is voluntary in all 11 states. Some states have been successful in recruiting commercial firms: Colorado has six commercial firms participating in its primary care practice transformation initiative, and Rhode Island has four major health plans participating in its PCMH Kids initiative. Other states have not been successful at recruiting commercial firms to adopt their SIM delivery system and payment reforms. Although New York had attained consensus among commercial firms on the definition of its APC model, at the time of the May 2016 site visit, the state had failed to get a commitment from any of its many major commercial payers to pay practices for implementing the APC model.

Health homes. Although focusing on different vulnerable populations, Colorado and Tennessee are developing health homes. Colorado, in its bidirectional health homes initiative, has funded the transformation of four community mental health centers into integrated health homes providing comprehensive, integrated, or co-located behavioral and physical health care to children, adolescents, and adults who receive the majority of their care at these centers. As of April 30, 2016, Tennessee was planning to launch its Health Link program, a health home program for high risk TennCare (the state's Medicaid program) patients with acute physical and behavioral health needs during fourth quarter 2016.

Accountable care organizations. Three other states—Connecticut, Michigan, and Washington—are using their SIM awards to establish Medicaid accountable care models. After a delay to address stakeholder concerns, Connecticut will launch its Person Centered Medical PCMH+ Program on January 1, 2017. This program will reward providers in Advanced Networks or FQHCs with shared savings for improving access, care coordination, health outcomes, and health equity. As of April 30, 2016, Michigan was planning to launch its Accountable Systems of Care (ASC) model for Medicaid in five regions of the state. Health plans and providers in ASCs will earn bonuses if they control spending growth below some target, while meeting standards of care based on a set of quality metrics. Medicaid managed care plans will be required to contract with ASCs, and ASCs will be required to include PCMH practices in their provider networks. In Washington, two insurance plans based on the state's Accountable Care Program became options for state employees in five counties, starting in January 2016. Under risk-based contracts with the state's Public Employee Benefits Board, the Accountable Care Networks (ACNs) assume clinical and financial risk for enrolled state employees.

Episodes of care. Ohio and Tennessee are implementing EOC payment models. Ohio will develop EOC models for up to 50 episodes. In each EOC model, one provider will be held accountable for the total episode-based cost and quality of care, with incentive payments tied to performance. The performance period for six, wave 1 episodes in Ohio Medicaid began in January 2016 and will begin for seven additional episodes in January 2017. Participation by commercial insurers in the state's EOC models is voluntary, whereas Medicaid managed care plans must use them. Tennessee plans to develop 75 EOC models by fourth quarter 2019, rolling out 6 to 8 new models every 6 months; the first wave of 3 EOC models went into effect in May 2014. As of the 2016 site visit, only Medicaid and the state employee plans were using the state's EOC models, but state officials expect commercial firms to adopt them.

Value-based payment in nursing facilities and home and community-based services. Tennessee will use its SIM award to build on existing initiatives focused on improving quality and shifting nursing facility services and home- and community-based services (HCBS) to value-based payment (VBP) for adults and seniors with physical disabilities and individuals with intellectual and developmental disabilities (I/DD). The new payment model includes (1) a monthly case rate that is front-loaded and reduced over time for behavioral health crisis care for persons with I/DD, implemented in January 2016; (2) a per diem bonus based on quality metrics for extended respiratory care providers and a managed LTSS program for individuals with I/DD, both implemented in July 2016; and (3) prospective rate adjustment based on quality scores for nursing homes, which will begin in January 2017.

2.3.2 Policy levers

The Round 2 Model Test states are using a range of policy levers to implement the delivery system and payment reform models (**Table 2-7**). Nearly every Round 2 Model Test state is using one or more policy levers related to its Medicaid program to mandate or encourage participation of payers and providers in these models. Seven states are including requirements in their MCO contracts, four have submitted state plan amendments, two have requested Medicaid waivers, and two have added requirements for provider participation in the delivery system and payment reform models.

New York and Delaware are using their authority as regulators of commercial insurance plans to promote health care transformation. New York is offering an adjustment to commercial payers' Medical Loss Ratio for 2017, to help offset new investments they may make in alignment with the APC model. In the Delaware health insurance marketplace, qualified health plans are expected to offer both total cost of care and pay-for-value models to primary care providers or their affiliated ACOs, health systems, and networks.

Table 2-7. State Innovation Model Initiative Round 2 Model Test states’ policy levers to promote health care delivery system and payment reform models

Policy levers	CO	CT	DE	ID	IA	MI	NY	OH	RI	TN	WA
Executive Order				X							
State legislation			X					X	X	X	X
Medicaid waivers										X	X
Medicaid state plan amendments				X				X	X	X	
Medicaid MCO contract requirements			X		X	X		X	X	X	X
Medicaid provider participation requirements	X									X	
State employee plan requirements							X				
MOU with payers to use APM for providers	X										
Standards for QHPs in marketplace			X								
Higher medical loss ratio for participating payers							X				
Delivery system certification requirements	X	X				X		X			
Practice transformation grants	X	X					X				
Convening						X	X	X		X	

APM = alternative payment model; MCO = managed care organization; MOU = memorandum of understanding; QHP = qualified health plan; X = policy lever that state has included in its plans for the SIM Initiative.

Several states are using political directives, such as Executive Orders and legislation, to spread health care transformation. In support of the Washington SIM Initiative, the state legislature enacted several key bills. House Bill (HB) 2572 (2013), “Better Health Care Purchasing,” directs the Health Care Authority to increase value-based contracting for Medicaid and public employees. Senate Bill 6312 (2013), “Treating the Whole Person,” established a phased approach for full integration of behavioral health in Medicaid managed care by 2020. Tennessee will use its authority under its Long-Term Care Community Choices Act of 2008¹⁴ and a 1915c Medicaid waiver amendment to implement several approaches to improving quality and promoting value-based purchasing for LTSS. In February 2014, the Idaho Governor used an Executive Order No. 2014-02¹⁵ to establish the Idaho Healthcare Coalition, which comprises key stakeholders from private and public sectors, to guide implementation of the SIM Initiative. In the biennial budget signed by the Ohio Governor in June 2015, a provision in Ohio Revised

¹⁴ Long-Term Care Community Choices Act of 2008, 2010 Tenn. Code Ann. §§ 71-5-1403 (2008).

¹⁵ Executive Order No. 2014-02, Establishing the Idaho Healthcare Coalition. Office of the Governor, State of Idaho. Retrieved from <https://gov.idaho.gov/mediacenter/execorders/eo14/EO%202014-02%20Establishing%20the%20Idaho%20Healthcare%20Coalition.pdf>

Code 5167.33¹⁶ requires that 50 percent of payments of the Medicaid managed care plans be value based by 2020.

Other policy levers include practice transformation grants; vendor contracts to provide TA to primary care and other practices; and workshops, seminars, and other public forums to raise awareness or educate stakeholders on the health care changes underway. For example, in 2016, Colorado chose 100 primary care practices to receive practice transformation grants of up to \$5,000 each, to use toward achieving a subset of SIM-established milestones. Colorado also is contracting with 17 organizations to provide assistance to these practices through practice transformation coaches. Other practice transformation efforts are described in *Section 2.6*.

2.4 Population Health–Oriented Models

The SIM Initiative is helping change the health care delivery system to a population health orientation that recognizes the critical role social determinants of health play in health care outcomes. Iowa stakeholders view the SIM Initiative as a catalyst for connecting public health and community-based services to the clinical health service sector. One stakeholder described this idea by saying that the SIM Initiative has the potential to elevate public health to a “chief health strategist” position within the health system, an atypical role for the state’s public health agency.

Integration of these diverse services brings together agencies and organizations that may have had only limited interaction in the past, and represents a fundamental shift in the way health care is organized and delivered. For example, Idaho’s RC structure combines the expertise of public health and primary care and helps to focus overall SIM Initiative efforts on health promotion rather than disease management. Similarly, the Michigan Community Health Innovation Regions (CHIRs) are addressing social determinants of health, including housing and nutrition needs, to support improved overall health and wellness.

Of the Round 2 SIM-supported models, those that integrate clinical, public health, and community-based services were identified by stakeholders in several states (Connecticut, Iowa, Idaho, Michigan, Ohio, and Washington) as the most innovative and most likely to make an impact on population health. However, these models also were considered by state officials and payers as the least likely to be sustained following the end of SIM funding (see discussion of sustainability in *Section 2.9.2*).

¹⁶ Strategies regarding payment to providers. [Ohio Rev Code § 5167.33 \(2015\)](#).

2.4.1 Strategies

States are taking a variety of approaches to identify and prioritize population health needs; link clinical, public health, and community-based resources; and address the social determinants of health to improve overall wellness. **Table 2-8** shows select, SIM-funded activities focused on improving the integration of clinical, public health, and community-based services.

Table 2-8. State Innovation Model Initiative Round 2 Model Test states' strategies and policy levers to promote population health improvement

Strategies and policy levers	CO	CT	DE	ID	IA	MI	NY	OH	RI	TN	WA
Strategies											
Establish local/regional entities to identify priorities and develop plan	(a)	X	X	X	X	X	X				X
Establish local/regional entities to integrate clinical and community services		X	X	X	X	X	X				X
Establish CBOs to provide prevention services		X			X						X
Use prevention/population health measures for incentive payments							X	X		X	X
Other activities	X			X	X				X	X	
Policy levers											
Grants/contracts to LPHAs or CBOs	X	X		X	X	X	X			X	
Contracts to develop analytic tools or analyses		X						X			
Delivery system certification requirements		X									
State legislation								X			X
Medicaid 1115 waiver											X

^a Colorado will deploy 21 Regional Health Connectors, individuals hosted by a local public health agency (LPHA) or other community-based organization (CBO) to facilitate alignment and linkage among clinical services, LPHA efforts, and broader community resources in their region of responsibility.

CBO = community-based organization; LPHA = local public health agency; X = strategy or policy lever that state has included in its plans for the SIM Initiative.

Six of the 11 Round 2 Model Test states are establishing different local or regional entities to identify and prioritize population health needs, build community coalitions to address those needs, provide clinicians with linkages to public health and community-based resources, and/or provide prevention or care coordination services.

- Connecticut will develop a comprehensive plan for Health Enhancement Communities—shared governance structures with multi-sector partners that can be held accountable for the health of the community at large. Connecticut also will use SIM funds to develop a proof-of-concept model for Prevention Service Centers—community-based organizations (CBOs) that provide evidence-informed, culturally and linguistically appropriate prevention services. Connecticut is implementing the Community Clinical Integration Program (CCIP) to address health equity gaps and improve outcomes and effectiveness of care by building linkages with community resources to manage care and develop clinical integration capabilities.
- Delaware plans to implement 10 Healthy Neighborhoods across the state. Based on the needs of their communities, each of these entities will focus on one or more of four priority areas: (1) healthy lifestyles, (2) maternal and child health, (3) mental health and addiction, and (4) chronic disease prevention and management. The entities will draft a 3-year, population health improvement plan and create, implement, and evaluate an outcomes-based action plan.
- Idaho is creating seven RCs through the state’s existing public health districts. Each RC is tasked with organizing its medical-health neighborhood, supporting local primary care practices in their PCMH transformation, and creating formal referral and feedback protocols that will better link local medical and social services providers.
- In Iowa, C3s, led by local health departments or large health care systems, will align priorities with their communities’ Community Health Needs Assessment and Health Improve Plans, build community coalitions, and implement rapid-cycle health improvement strategies.
- Michigan’s CHIRs will work with ASCs and health care providers to identify local health needs and support integration between health and other community-based services. Each CHIR will focus on improving outcomes for three priority populations: (1) emergency room (ER) super-utilizers, (2) healthy mothers and babies, and (3) individuals with multiple chronic conditions.
- Washington established nine regional ACHs, which bring together local stakeholders from multiple sectors to determine priorities for regional health improvement projects and implement these locally driven projects. Washington is developing its Plan for Improving Population Health, which is intended to establish an overall state population health strategy, including tools ACH stakeholders can use to improve population health.

Instead of establishing new entities to connect primary care practices to public health agencies and other community partners, some states are using existing entities to implement their population health strategies. Colorado is deploying a new workforce of 21 Regional Health Connectors, each hosted by an LPHA or other CBO. New York originally envisioned funding public health consultants to encourage APC practices to refer patients to social services in the community. However, concerned that a single individual would not be sufficient to meaningfully influence population health in a given area, New York is considering awarding SIM funds

instead to a few local public health departments or other CBOs, to bring together key stakeholders in their communities to collectively address a common health improvement goal. These multi-sector collaborations would be charged with developing a portfolio of interventions to address population health priorities.

Several Round 2 Model Test states (New York, Ohio, Tennessee, and Washington) added, or are planning to add, population health measures to their quality scorecards used to qualify practices as medical homes or determine incentive payments. For example, Ohio aligned its population health priorities with clinical quality measures for the PCMH model. To be considered for the cross-payer alignment on PCMH quality metrics, measures had to align with Ohio population health priorities.

Other states are implementing a variety of different population health efforts. Colorado is developing primary care provider education tools on screening for pregnancy-related depression, depression in the general population, obesity, and other behavioral health disorders. Idaho is augmenting its PCMH staff with community health workers (CHWs) and community health emergency medical services (CHEMS) that will, among other things, provide health education and outreach and promote patient self-management for individuals with chronic diseases in remote rural areas. Iowa is developing a database to assess and track clinical indicators related to health improvement plans. Tennessee is developing a Web site to house a matrix of options for policies, programs, and best practices on different public health topics. Rhode Island is developing a population health plan that incorporates behavioral health into all its SIM models and strategies.

2.4.2 Policy levers

The most common policy levers Round 2 Model Test states are using to promote population health activities are grants and contracts to LPHAs or CBOs. Colorado is awarding grants to LPHAs and other community-based agencies to host a regional health connector, and to LPHAs and behavioral health organizations to build community coalition and support activities in stigma reduction and promotion of best practices in mental health screening. Idaho is contracting with the state's seven public health districts to establish and support the RCs. Iowa is awarding grants to C3s to focus on either building coalitions or implementing health improvement strategies. Michigan will contract with a "backbone organization" in each of five regions of the state to support CHIR development and processes that integrate with established clinical, public health, and community-based resources.

Connecticut and Ohio have established contracts to improve population health data and analytics infrastructure. Connecticut contracted with the University of Connecticut Data Center to develop a small area estimation demographic model for population health analysis and will contract with a consultant to facilitate a root cause and barrier analysis on identified priorities.

Ohio has contracted with the Health Policy Institute of Ohio to develop the statewide needs assessment and guidance for local assessments.

Other policy levers include delivery system certification requirements, state legislation, and a Medicaid 1115 waiver. New York's APC practices must meet population health milestones to become certified as meeting the highest level of medical home certification offered through the SIM Initiative (Gate 3 of the state's APC model), which is expected to yield them the highest payments from payers. Ohio enacted legislation (ORC 3701.981) to (1) align timeframes for conducting population health assessments required of local health departments and community benefit hospitals by 2020, and (2) require reports to be made public in a new repository. Connecticut will be exploring legislative opportunities to establish a framework for Health Enhancement Community designation. Washington submitted a Medicaid 1115 transformation waiver request that includes support for ACHs. As of the end of the AR1 analysis period, June 30, 2016, this waiver has not been approved.

2.5 Health Information Technology and Data Analytic Infrastructure

Robust health IT systems and data analytic infrastructures provide the foundation needed for the health care delivery system and payment reform models being implemented under the SIM Initiative to achieve better care, smarter spending, and a healthier nation. In particular, this infrastructure allows providers and other health decision makers to store, share, analyze, and act on patient- and population-level health information.

2.5.1 Strategies

Building health IT and data infrastructure capacity is key to all Round 2 Model Test states' SIM Operational Plans. As shown in **Table 2-9**, however, each state has a different set of infrastructure needs and strategies planned for implementation under the SIM Initiative.

Electronic health records and data transfer. Six Round 2 Model Test states have strategies related to the sharing of health-related data. Adoption and use of EHRs and data transfer by more primary care practices, behavioral health providers, other specialists, and LTSS providers is a key strategy in Delaware and Idaho. Delaware budgeted a significant portion of SIM funds to support 50 behavioral health providers in their EHR adoption. Similarly, Idaho is devoting significant resources to increasing EHR utilization and expanding participation in the Idaho Health Data Exchange (IHDE). Iowa and Michigan are two examples of states that are promoting admission, discharge, and transfer (ADT) notifications. To increase provider interest in information-sharing, Iowa's SIM Initiative includes implementation of a Statewide Alert Notification system designed to allow providers to obtain timely ADT information on their hospitalized patients—the providers can follow up and work with others, such as C3s, to

Table 2-9. State Innovation Model Initiative Round 2 Model Test states’ health information technology and data infrastructure and analysis strategies and policy levers

Strategies and policy levers	CO	CT	DE	ID	IA	MI	NY	OH	RI	TN	WA
Strategies											
Promote adoption and use of EHRs			X	X							
Establish, promote HIE adoption and enhancement		X	X	X	X	X				X	
Increase data analytic capability		X		X	X		X				X
Develop common set of core quality metrics	X	X	X	X	X	X	X	X	X		X
Develop or enhance APCD			X				X		X		X
Develop quality reporting system		X	X	X		X	X	X	X	X	
Expand telehealth	X			X							
Develop data hub and repository	X								X		X
Policy levers											
Practice transformation grants	X	X	X	X			X				
State legislation		X	X								X
Delivery system certification requirements				X		X	X				
Contracting	X			X							X

APCD = all-payer claims database; EHR = electronic health record; HIE = health information exchange; SIM = State Innovation Model; X = strategy or policy lever that state has included in its plans for the SIM Initiative.

coordinate care for the patient. Michigan also is planning to enhance the use of its health information exchange (HIE), the Michigan Health Information Network, for care coordination through ADT notification and active care relationship (similar to patient attribution) use cases. Michigan also plans to use its HIE to track a broad set of population health metrics to inform ongoing needs assessments in each of the project’s five CHIRs.

Data analytic capacity. Another major strategy in the Round 2 Model Test state SIM Operational Plans is increasing data analytic capacity.

- Colorado will build a more refined, centralized data hub. The hub, known as the quality measures reporting tool + (QMRT+), will be used to collect, quality check, store, aggregate, and report out clinical quality measures data collected through providers’ EHRs. QMRT+ also is expected to link to the all-payer claims database (APCD) to facilitate cost of care aggregation and reporting for providers, payers, and the public health community.
- Rhode Island will support development of a modern system for integrating person-level data across Rhode Island’s Executive Office of Health and Human Services agencies. This system will allow state officials to share data more effectively and develop new approaches for analyzing the data to better inform state policymaking.

- To connect state data systems to clinical data systems for assessing population health, Washington created the Analytics, Interoperability, Measurement strategy. This strategy draws on existing and ongoing state efforts—including an APCD, a statewide common measure set, and a clinical data repository. The clinical data repository will make clinical data, including physical and mental health information, available to (1) providers to improve care delivery and (2) state officials for performance measurement.

Common set of quality measures. Ten Round 2 Model Test states (Colorado, Connecticut, Delaware, Idaho, Iowa, Michigan, New York, Ohio, Rhode Island, and Washington) are developing a common set of quality measures to use in certifying practices as PCMHs and/or for determining quality incentive payments. Here are four examples. Delaware developed a common scorecard—a set of 26 measures selected through a stakeholder consensus process that payers will use to support their payment reform models. This common scorecard was pilot tested in 21 practices in 2015. Idaho used a stakeholder consensus process to develop an initial performance measures catalog that includes standardized definitions of each measure’s numerator, denominator, and data sources. New York plans to provide APC practices with a common scorecard summarizing their performance on a common set of quality measures for patients insured through multiple payers. Rhode Island has developed an aligned measure set with 59 measures—including core measure sets for ACOs, primary care providers, and hospitals.

Telehealth. Two Round 2 Model Test states (Colorado, Idaho) are implementing a telehealth strategy under the SIM Initiative. Colorado has contracted with a local policy institute to develop a statewide strategy to implement telehealth. Beginning in 2017, insurers in the state will be mandated to reimburse both the originating provider (if a visit with the originating provider precedes the telemedicine consultations) and the distant provider for telemedicine visits. Idaho is seeking to alleviate primary care provider shortages in rural areas by adding “virtual PCMHs” to its primary care system. To become a virtual PCMH, a primary care practice that has met PCMH qualification must embed one or more of three modules into its practice: telehealth, CHEMS, or CHWs. Stakeholders believed that telehealth would be especially useful for improving access to specialty and behavioral health services through PCMHs. At the time of the 2016 site visit, Idaho was still designing its telehealth expansion, determining how the expansion will be integrated into the PCMH model and how services will be reimbursed.

Other data analytic capacity building strategies under the Round 2 Model States’ SIM Initiatives include developing or enhancing an APCD (Delaware, New York, Rhode Island, Washington), and preparing and operationalizing a common provider directory (Rhode Island). To support total cost of care payment, Delaware is developing an APCD that includes claims data from Medicaid, qualified health plans in the marketplace, state employee plans, and other payers (voluntarily). The DCHI Board approved a consensus white paper on APCD establishment, governance, and implementation. New York has been developing its APCD since 2012 and plans to have its APCD operational for use in its APC Scorecard by 2017. The state’s

SIM health IT work group has been working on developing regulations for the Statewide Health Information Network for New York (the state's HIE), the New York APCD, and the APC Scorecard. The Rhode Island and Washington APCDs are also continuations and enhancements of pre-SIM Initiative efforts. Enhancements include the reporting of cost data. Rhode Island is also using SIM funds to operationalize a provider directory, a Web-based database of detailed provider information (such as demographics; contact information; and relationships to practices, hospitals, ACOs and health plans).

2.5.2 Policy levers

Policy levers the Round 2 Model Test states are using to promote their SIM Initiative health IT and data analytic infrastructure strategies include grants for connecting to the statewide HIE, state legislation, delivery system certification, and contracts.

The majority of physician practices in Delaware are small independent practices. One goal of its SIM Initiative is assisting such practices to become electronic, while keeping the costs to them as low as possible. More challenging, however, is getting behavioral health and LTSS providers, which have not been eligible for the Health Information Technology for Economic and Clinical Health (HITECH) incentive program, able to submit and share data through the Delaware Health Information Network. Delaware is using an Office of the National Coordinator for Health Information Technology (ONC) grant and its SIM Initiative to offer long-term care facilities 2 years of no-cost, secure messaging and data extracts from the Long-Term Care Minimum Data Set and the Outcomes and Assessment Information Set (OASIS) that long-term care facilities provide to CMS. In addition, the state has budgeted \$500,000 of its SIM funds to help behavioral health providers adopt EHRs.

Idaho is also working to engage other types of providers and more payers in IHDE by developing use cases that show how the IHDE can be used to meet provider and payer goals. But few providers are exchanging information via the IHDE, which was created in 2009, despite the relatively high prevalence of EHRs in primary care practices in Idaho. Most focus group physicians reported that they still receive follow-up specialist or hospital visit information via fax. Barriers appear to be the high cost of connecting to the IHDE and its limited usefulness. The IHDE often does not have much information beyond that already known to the practice, according to stakeholders, because providers are not contributing their data, and many patients obtain services outside the state (from providers in Salt Lake City or Spokane). The SIM Initiative aims to improve the usefulness of the IHDE by increasing the number of providers uploading data and offering TA to incorporate routine use of the data into their workflows. Idaho's SIM Initiative is incentivizing practices to join the IHDE by covering the costs of connecting their EHRs to the IHDE and offering increased per member per month (PMPM) reimbursement from Medicaid for being connected.

To foster their health IT and data analytic infrastructure strategies, Connecticut, Delaware, and Washington enacted state legislation. Connecticut, which has lagged in putting together a health IT plan, enacted legislation at the end of the 2016 legislative session to create a state health IT officer and move oversight from the state Department of Social Services to the Lieutenant Governor. This transition may help align what stakeholders describe as a disjointed health IT strategy. During its most recent legislative session, Delaware passed legislation to provide statutory authority for the Delaware Health Information Network to administer and operate an APCD. The legislation mandates collection of Medicaid, qualified health plans in the marketplace, and state employee claims data. The legislation also authorizes collection of voluntary data from other payers. On May 14, 2015, Washington enacted legislation authoring the administration and operation of an APCD, which could include the reporting of cost data. At the time of the 2016 site visit, 20 data suppliers contribute claims and quality data to a voluntary APCD and Washington is soliciting a vendor to build its APCD.

2.6 Practice Transformation Facilitation and Workforce Development

The health care delivery system and payment reform models supported by the SIM Initiative Round 2 Model Test states require new clinical workflows and professional roles, most notably in primary care practices. Consequently, all Round 2 Model Test states are using practice transformation facilitation, workforce development strategies, and policy levers to support their SIM awards. The SIM practice transformation facilitation, workforce development strategies, and policy levers typically run parallel to existing health care workforce initiatives in the states.

2.6.1 Strategies

As shown in *Table 2-10*, the Round 2 Model Test states are taking a variety of approaches to developing the health care workforce.

All Round 2 Model Test states except Iowa included some form of primary care practice transformation facilitation in their SIM award. Iowa focused its workforce development plan on providing lead organizations of C3s TA in coalition building and rapid-cycle improvements, through learning communities, site visits, and one-on-one coaching. The primary care practice transformation assistance offered by the other 10 states was varied, but frequently included learning collaboratives and one-on-one coaching and/or TA.

- The Colorado SIM Initiative is supporting primary care practice transformation by providing a learning collaborative and practice transformation coaches. The coach and the practice will jointly design improvement plans based on 10 milestones set by the state.

Table 2-10. State Innovation Model Initiative Round 2 Model Test states’ practice transformation facilitation and workforce development strategies and policy levers

Strategies and policy levers	CO	CT	DE	ID	IA	MI	NY	OH	RI	TN	WA
Strategies											
Learning collaboratives for primary care practices	X	X		X		X				X	
Other TA for primary care practices	X	X	X	X		X	X	X	X	X	X
Mental health consultation teams and referral services									X		
Learning collaboratives and other TA to CBOs					X					X	
Telehealth				X							
Develop curriculum, train and hire community workers		X		X					X		
Practice transformation support hub				X							X
Policy levers											
Practice transformation or other grants	X	X		X	X						
Contracts with vendors for practice transformation		X	X	X			X			X	X
Loan forgiveness programs	(a)	X									
Rural medical residency program							X				
New GME formula to support workforce								X			

^a Colorado is investigating expanding its placement and loan forgiveness programs for health workforce members. CBO = community-based organization; GME = graduate medical education; TA = technical assistance; X = strategy or policy lever that state has included in its plans for the SIM Initiative.

- Michigan has contracted with the Institute for Healthcare Improvement to develop a Collaborative Learning Network, which will provide shared learning opportunities and individualized coaching to SIM participants and regions.
- Tennessee is funding training and a learning collaborative for behavioral health workers on the Health Link model, and developing a registry of and curriculum for credentialed LTSS direct care workers.
- Through its CCIP, Connecticut will offer targeted TA to 26 Advanced Networks or FQHCs participating in PCMH+—to enhance organizational capabilities in comprehensive care management, health equity intervention, and behavioral health integration.

- Idaho uses its PCMH contractor to offer primary care practices a TA package tailored to their needs and priorities—including a learning collaborative, webinars, and individual coaching
- Delaware, New York, Tennessee, and Washington are contracting with vendors to provide TA to primary care practices in making necessary changes to achieve the goals of the new delivery system and payment models.
- Rhode Island will convene a learning collaborative of providers and payers engaged in implementing VBPs.

Community health teams. Rhode Island will use SIM funds to support and expand community health teams—multidisciplinary teams that provide health coaching and care coordination services to primary care providers and address the social and environmental determinants of health that affect the most vulnerable populations.

Support hubs. Washington and Idaho are establishing practice transformation support hubs that will offer a centralized location where providers can learn about available transformation assistance. Washington’s hub is both a portal for resources to providers and an avenue for providing practice transformation assistance. The hub will connect providers to community resources and tools for effective and efficient practice. Idaho is using its RCs to collaborate with the PCMH contractor to (1) identify resources and TA to support transformation and quality improvement and (2) support PCMH data collection and reporting by connecting PCMHs to resources and expertise available through the IHDE.

Curriculum development. Building on ideas generated during an April 2014 Workforce Symposium, Delaware is developing a 2-year curriculum for health care workers, which will focus on communication and counseling skills, collaborative report writing, interprofessional practice, navigation and access to resources, care decisions and transitions-of-care planning, and health IT.

New types of health care professionals. Four states are developing new types of health care professionals to assist primary care physicians meet the requirements of the new delivery system and payment models.

- Connecticut is developing protocols for CHW apprenticeships, and identifying and filling potential CHW placements in primary care practices. These workers will conduct care coordination for a variety of populations—including people with complex care needs, non-English speaking populations, state retirees, and individuals in need of addiction and behavioral health services.
- Delaware is standardizing training for CHWs and making them a recognized discipline within the health workforce, so Medicaid and commercial insurance payments can be used to support their activities.

- Idaho has selected a curriculum and plans to train up to 200 CHWs and 52 CHEMS by the end of Award Year 4—who will conduct home visits and help patients access community resources.

Recruitment and retention. New York focused its early workforce development activities on increasing the number of primary care physicians practicing in New York and improving their distribution. The state is using SIM funds to develop requests for applications for a rural residency program to bring medical residents into rural (non-teaching) hospitals, and a physician retention initiative to expose physicians trained in New York to opportunities for practice in upstate and rural areas.

2.6.2 Policy levers

Besides the vendor contracts for practice transformation facilitation discussed above, states are providing primary care providers practice transformation grants. Colorado’s small grants program has two sources of funding, one from the SIM Initiative, the other from The Colorado Health Foundation. SIM funds can be used to support the training and onboarding of clinical staff. The Colorado Health Foundation funds can be used as seed funding to support the hiring (or contracting) and initial salary expenses of behavioral health clinicians. In Connecticut, practices committed to meeting CCIP standards will receive transformation grants to support relevant activities. Iowa is offering C3 lead organizations developmental grants to focus on coalition building or, where a coalition already exists, grants to begin implementing strategies in their communities.

Other policy levers states are using or considering include loan forgiveness programs, rural medical residency programs, and refocusing Medicaid direct graduate medical education (GME) funds. Connecticut is considering loan forgiveness programs to support the retention of residents in primary care. As noted, New York is establishing a rural residency program and a physician retention initiative to strengthen its rural workforce.

2.7 Consumer Engagement

2.7.1 Strategies

Few Round 2 Model Test states mentioned formal strategies to engage consumers in health care decision-making; exceptions included Delaware, Washington, Connecticut, and New York. In the Delaware SIM Initiative, patient engagement is one of seven major strategies to transform the health care delivery system. Delaware plans to engage patients in their health care through access to their community health record, as well as health literacy, patient portal, advanced care planning, and other tools. Delaware also intends to shift the focus toward individuals taking responsibility for disease prevention and chronic disease management. During the reporting period, Washington implemented a process to certify patient decision aids and began accepting aids for certification in April 2016. Washington plans to spread the use of the

certified aids through the HUB and by requiring their use by the networks participating in the Accountable Care Program (Payment Model 3).

Two states, Connecticut and New York, are developing VBID plans. Connecticut is using its Health Enhancement Program—a value-based insurance program that offers reduced monthly premiums and lower cost-sharing for state employees who commit to receive certain preventive care—as an important building block for the multi-payer VBID initiative developing under the SIM Initiative. The state plans to expand VBID to additional employers through the SIM Initiative and will use the success of the state employee program as a model. New York also has plans to incorporate VBID principles into the state employee health plans. However, at the time of the May 2016 site visit, SIM staff had made no progress in convincing the state’s Department of Civil Services, which negotiates with state employee unions, to make changes to the New York State Health Insurance Plan.

2.7.2 Policy levers

Three states have used policy levers to promote consumer engagement. Legislation passed in Washington granted the Health Care Authority’s chief medical officer the authority to certify patient decision aids, which, if signed by a patient, constitute informed consent. Delaware is hosting a series of six town hall meetings to engage and educate consumers about the SIM Initiative beginning May 2016, and has scheduled television and radio spots for later the same year. Similarly, Colorado conducted an outreach tour, called the SIM Roadshow, which held town hall meetings in cities and towns throughout the state.

2.8 Technical Assistance and Other Support Resources

Officials from the Round 2 Model Test states generally expressed positive experiences with the TA and support provided through CMMI and its contractors. Officials in Delaware, Rhode Island, and Washington noted the CMS site visit as being especially helpful, citing the greater understanding they gained of the CMS vision provided from the State Innovations Group leader’s presentation during the visit. This insight has helped them make adjustments to their SIM Operational Plans.

The states had positive reactions to the assistance that they received from CMMI. Colorado officials found the crosswalks and state-to-state sharing, and assistance with memos and other materials, to be particularly helpful. Connecticut appreciated the manner in which CMMI handled the change in Project Officers, providing background support as needed to ensure continuity and being generous with their time. Delaware noted CMMI’s responsiveness to questions about report submissions. Idaho pointed to the assistance given on engaging self-funded employers as particularly helpful. New York found being put in touch with their counterparts in other states to be very useful. A Washington state official noted a positive experience in which CMMI connected the state with another Round 2 Model Test awardee for

advice on designing the practice transformation support hub. Both Connecticut and Rhode Island officials noted the invaluable, high-level TA on health IT strategy ONC provided. New York officials mentioned helpful feedback from a Centers for Disease Control and Prevention (CDC) expert on population health components of its SIM Initiative.

2.8.1 Challenges

Despite the generally positive experiences, seven states (Colorado, Connecticut, Idaho, Iowa, Rhode Island, Ohio, and Tennessee) noted some challenges in working with CMS and its contractors. In particular, states found the CMS grants management approach challenging. Because initiatives move at different paces and often vary from the original plan, state officials found the individual year award difficult to manage in such a large, innovative project. These officials want to be able to move forward when stakeholders are ready, but found that the grants administration process often precluded such movement, due to the time required for CMS to respond to state requests. The process for CMS to approve contracts issued by the states in some instances took more than several months to complete, which impeded the states' ability to implement their SIM Operational Plans on schedule.

Other challenges in the technical support the states faced included changes to purchase orders, which led to confusion over administrative issues; the burden and short timeframes of the many CMS requests for detailed information; and the lack of coordination across parts of CMS (e.g., Center for Medicaid and CHIP Services and CMMI). Furthermore, state officials believed that CMS lost an opportunity to inform them about the CPC+ and Core Quality Measures before the joint announcement of these initiatives was released.¹⁷ Finally, some state officials found TA contractors were responsive but did not dig deeply into a subject—in particular, they did not go beyond publicly available resources on websites. On the other hand, some state officials would have preferred to receive more summary information. In particular, Those officials would like the TA contractors to provide an analysis of the available information on SIM-related models and strategies, drawing out the key information and options needed to make decisions.

2.8.2 Suggestions

State officials had the following suggestions for CMMI staff:

- Provide states more flexibility in shifting SIM funds to meet unfolding needs.¹⁸
- Be more proactive in providing information about strategies and lessons learned in other SIM states.

¹⁷ While state officials expressed a desire to have more information about other initiatives in advance of their official announcement, for CMS to do so is a violation of federal law. Therefore, early information about CPC+ was not an option, regardless of how helpful the Model Test states might have found the advance information.

¹⁸ CMMI is currently able to allow some flexibility; however, CMMI still has to ensure the proposed modified use is allowable and relates to the Model Test state's project.

- Organize a second nationwide, in-person SIM meeting to facilitate information sharing and relationship building among the Model Test states.
- Provide more assistance in engaging Medicare in the SIM Initiative.

2.9 Progress and Challenges

2.9.1 Progress to date

At the time of the first set of site visits for the federal evaluation (April to June 2016), most Round 2 Model Test states were just a few months into Award Year 2. The states had taken the first year to hire staff, procure contractors, prepare and enact enabling legislation and regulations, and work out the details and implementation of their SIM awards. Many states had several key components of the Operational Plan under way, but some (e.g., Connecticut, Iowa, Michigan) faced challenges.

The following are examples of the progress states had made with their delivery systems and payment models by the 2016 site visits. Colorado had launched its primary care practice transformation and bidirectional health homes models; Idaho, its PCMH model; Rhode Island, its PCMH Kids model; Tennessee, its EOC and Health Links models; and Washington, its Medicaid early adopter and ACN models. All these delivery system and payment models were implemented in a small set of qualifying practices or a select region of the state; none were implemented statewide. Other models in these states and in other states were scheduled to be launched in summer or fall 2016 or early 2017. All states were continuing to work out details of payment models, and engaging payers and providers in the different delivery system and payment models and activities.

Of the six states establishing local or regional models to move the health care delivery system toward a population health orientation, only Idaho, which is using its existing public health structure, had set up entities statewide at the time of the 2016 site visit. Four of these states had selected or begun operation of these entities in substate areas. In Delaware, the first 3 of 10 Healthy Neighborhoods had been selected, and planning at the community level had begun. Six C3s, representing 20 of Iowa's 99 counties, had been awarded grants to build community coalitions or implement health improvement strategies. "Backbone organizations" for the Michigan CHIRs in five regions of the state had been selected and are expected to be operational in late 2016. And, although most ACHs in Washington were still in the planning stages, two of the regional entities had launched pilot projects. In Colorado, five LPHAs and three regional public health collaboratives had been awarded grants to support behavioral health activities.

Stakeholders talking regularly. Although it is too early to determine whether the SIM Initiative has led to any lasting impact on health care quality, costs, or outcomes, progress to date suggests that leadership from the Governor's Office can serve as a successful catalyst for

convening stakeholders and identifying a plan for transformation of the state’s health care system. Many stakeholders from across the Round 2 Model Test states noted that the SIM process started a lot of stakeholders—payers, providers, consumers, and employers—talking to each other regularly, which was not happening before the SIM Initiative. The Governor’s backing legitimized the effort and provided the structure and vision for going forward.

Improved alignment across state agencies. Officials in a few Round 2 Model Test states noted that the SIM Initiative is facilitating better alignment across state agencies. Typically, care delivery systems for medical care, public health, behavioral health, and LTSS work in siloes within state governments. Even within behavioral health, mental health services are often provided by one agency and substance abuse services by another. Iowa officials noted that the SIM Initiative requires building new relationships across care systems, particularly at the community level. Rhode Island officials attributed closer working relationships across agencies to the SIM Initiative supporting more interagency projects than in the past. An Ohio state official discussed that the Office of Health Transformation is streamlining health and human services by aligning state agencies under its oversight. These agencies include not just Medicaid, but also the Department of Health, the Department of Developmental Disabilities, and the Department of Mental Health and Addiction Services. Ohio’s Office of Health Transformation also works with the Department of Job and Family Services, the Department of Education, the Office of Budget and Management, the Department of Taxation, the Department of Insurance, and other state-level agencies.

2.9.2 Challenges to date

Leadership and collaboration

The SIM Initiative is led out of a variety of existing and new state government offices and agencies. Most stakeholders reported that their state’s SIM governance structure was working well, but not without challenges. Examples of challenges to leadership and collaboration follow.

Limited administrative capacity and experience. In Connecticut, SIM leadership is not in an agency directly responsible for existing state programs, such as Medicaid, public health, or mental health and addiction services. Although this structure preserved neutrality, it meant that SIM leadership had limited administrative capacity and little experience with contracting and procurement processes, a major requirement for the SIM Initiative. Furthermore, leadership has to be sensitive to the interplay between existing program structures and the program oversight council, in terms of clarifying advisory and decision-making roles. Developing a protocol for communication between the SIM work groups and the Medicaid oversight council, for example, was very helpful.

Iowa and Delaware mentioned the difficulty their SIM leadership faces in getting some communities involved in SIM Initiative efforts. Iowa stakeholders noted that building new relationships across different care systems at the community level is particularly challenging in small, rural communities, where resources are stretched thin. Delaware stakeholders expressed concern that involvement in, and commitment to, the SIM Initiative may not run very deep within some organizations, noting the need for leadership to drive involvement throughout middle management of state agencies (such as the Division of Public Health) to further cement SIM goals and activities into the state culture and to begin to develop coordination with state-led public health programs.

Work group challenges. While most stakeholders were generally pleased with the selection process for work group members and impressed with the diverse stakeholder representation on each committee, they did have work group challenges. Some stakeholders in Connecticut felt too many people were engaged, thus slowing down the process, and that meetings were lengthy and not efficient, giving rise to work group member burnout.

Rhode Island stakeholders noted challenges with gaining consensus from a large and diverse group of stakeholders, including finding the right structure for Steering Committee conversations. The SIM Core Team in the state tried to facilitate the consensus process by working with the Interagency Planning Team and work groups to think through issues before bringing them to the Steering Committee and by developing visuals illustrating SIM activities by domain and affected groups to better guide committee discussions and decisions.

As Colorado's SIM Initiative moved from the development phase toward implementation, its work groups became less directive and more focused on discussions about how to proceed. This shift was described as both an opportunity and a challenge: Work groups were able to self-direct actions and decisions, but the lack of high-level directives from SIM leadership sometimes led to ambiguity. One consumer advocate said the absence of direction made it unclear whether the work group's charge was to provide a recommendation versus a decision to the SIM office.

Value of stakeholder feedback. Interviewees identified circumstances that made them believe states were not considering stakeholder feedback. Some Rhode Island stakeholders noted that the short timeframes in which SIM leadership had to make decisions and return deliverables to CMS sometimes limited the extent to which committee members were able to provide input into SIM activities. In seven Round 2 Model Test states (Delaware, Colorado, Iowa, Ohio, New York, Rhode Island, and Tennessee), stakeholders perceived that the state had pre-determined priorities, and consequently did not adequately incorporate their feedback. For example, in Ohio, though generally supportive of the state's efforts, some stakeholders observed that the state's EOC contractor was especially influential in designing the models, perhaps because of the model's very technical requirements. One payer noted, "The state relies very heavily on

consultants. Often times, regardless of feedback from stakeholders, they have their mind made up on how everything is going to work. Even though you have the opportunity to provide feedback, I am not sure there is always that opportunity to affect the outcome.” In Tennessee, another state implementing the EOC model, stakeholders expressed similar sentiments; one provider characterized the dynamic as “dialog but not movement.”

Implementation timeline too short. Stakeholders in three states (Iowa, New York, and Tennessee) noted the aggressive implementation timeline. Payers and providers in Tennessee felt that the timeline for implementing different SIM components could have been more spread out to ease the internal burden. A New York payer noted that, from that payer’s experience, the process of contracting with providers and setting up care management departments in practices is much more drawn out than allowed under the SIM timeline. A New York state official also mentioned the extensive time needed for negotiating contracts with payers. Iowa officials and stakeholders expressed concern about the 3-year time frame of the test period, given the ambitious nature of the project and the complications brought on by the state’s recent switch to Medicaid managed care, which was unrelated to, and uncoordinated with, SIM transformation efforts.

Dynamic health care landscape

The SIM Initiative is being implemented in an ever-changing dynamic environment. Shocks to the health care system can occur from a number of sources—including a change in state or SIM leadership or shifts in the economy. These changes take resources and time to manage, and can lead to a perceived or real conflict with SIM objectives and incentives, significantly impeding its progress.

For example, the Iowa Medicaid program is in the midst of a shift from fee for service to managed care. This shift has changed the focus of the state from transforming the health care system to reducing Medicaid costs, caused some beneficiaries to change their usual source of care, and taken control out of the local level and into the hands of national plans. Some Iowa stakeholders are concerned that the introduction of managed care also changes the structure of the collaboration around SIM implementation. These stakeholders contended that placing an additional entity—the MCOs—between providers and the state agencies will reestablish the siloes in the system that had started to break down under early SIM implementation.

In Michigan, Medicaid managed care contracts were rebid in fall 2015, the same time that planning was under way for the SIM Initiative. The state stopped all communication with stakeholders about the SIM Initiative while this contracting process was under way, to avoid influencing the contents of the managed care plans’ proposals. The state did not connect with stakeholders at all during this time, and as a result, experienced delays in engagement and joint planning for SIM implementation. This delay, however, was temporary; when communication resumed, stakeholders were eager to begin implementing elements of the SIM Initiative. Further,

in Michigan, the Flint water crisis redirected the time and energy of many staff who would otherwise have been involved in the SIM Initiative.

Another example of unanticipated change is the demise of Health Republic Insurance of New York, a consumer-oriented and operated insurance plan established to compete in New York's ACA health insurance marketplace. The failure of Health Republic has raised questions about whether the state should continue to have the authority to review and approve health insurers' annual premium increases, given the state approved low premiums for Health Republic, but then needed to shut the plan down due to financial losses. The ability to approve or deny proposed increases to premiums is an important policy lever New York hopes to use to incentivize insurers to offer new payments to practices that adopt the state's APC model—such as by allowing plans to include new APC payments within the numerator of their Medical Loss Ratio.

Furthermore, the state political and fiscal landscape can pose additional challenges. Health care transformation priorities laid out by one governor may not be embraced by the next governor. Some states have experienced or are expecting changes in state leadership. The current Ohio Governor, for instance, was reelected in 2014 for a second 4-year term, and is not eligible for another term. Delaware's governorship is also term-limited, requiring the state to undergo a change in administration at the beginning of 2017. During the Connecticut site visit, nearly all officials, as well as many other stakeholders, alluded to the state's structural budget deficit as a major obstacle—affecting the ability of the state to fill SIM positions and jeopardizing participation by the state's Medicaid program in some SIM-related activities.

Coordination with other initiatives

All SIM Round 2 Model Test states participate in a number of other federal, state, and private health care delivery system and payment reform initiatives (see ***Section 2.1.2*** and ***Appendix M, Table M-1***). The SIM Initiative can enhance the effects of these other efforts. A Tennessee consumer advocate noted that the SIM Initiative has already served as an effect modifier for Vanderbilt's 4-year, \$28 million TCPI grant from CMS, as well as care coordination efforts in Memphis.

However, as noted by a New York state official, the numerous other initiatives operating or about to be launched in the state can also cause a lot of confusion and fatigue among both payers and providers. Stakeholders in Colorado and Washington noted that with provider systems, plans, and CBOs all doing care coordination, the coordinators themselves need coordination.

Some states have reacted to this challenge by developing models under their SIM Initiatives that complement rather than compete with existing initiatives and/or using SIM funds to develop policies and infrastructure that coordinate or align the various initiatives within the

state. For example, Rhode Island stakeholder interviewees noted that they made an effort not to duplicate any of the other delivery system and payment reform efforts, and instead, used SIM funding to develop supports that help the state’s ongoing efforts (e.g., Reinventing Medicaid, Medicaid’s rebid of its managed care contracts, development of Accountable Entities) to reach shared goals of better integration of physical and behavioral health, improved care, and lower costs. Similarly, most of the payers interviewed in Tennessee said the state’s SIM PCMH program for Medicaid beneficiaries would run parallel to their existing program, rather than replace them. This situation is a result of Tennessee’s decision to allow flexibility in the PCMH payment structure and other implementation decisions by health plans and providers.

The Round 2 Test states are using SIM funds to align quality measures, reporting requirements, payment policies, and data sharing infrastructure and processes across the different initiatives. However, as noted below, these alignment efforts have their own challenges.

Payer engagement

Commercial payers. Seven of the Round 2 Model Test states (Colorado, Connecticut, Idaho, New York, Rhode Island, and Washington) noted challenges engaging commercial payers in payment reform. These payers generally support SIM goals, but would prefer to continue to set their own direction for provider payment. Many commercial firms have well-established VBP models that they believe already incorporate the basic elements of the state programs or go beyond them.

Firms that are in competitive insurance market places, or national in scope, face additional obstacles. Due to having to negotiate with and come to a consensus across multiple parties, getting cooperation from a large number of commercial insurers with modest market share is inherently more difficult than getting the cooperation of a single dominant insurer. In addition, commercial payers in competitive markets often seek to differentiate themselves to gain market share—one way of differentiating being through innovative provider payment models. Implementing VBP in a standardized way in a competitive market would go against this business strategy. Nationally based firms may need to create a plan specific to the state or, as was done by Highmark BCBS in Delaware, one that works across state lines. Either option increases administrative burden for these national commercial payers and can take time to implement.

Furthermore, models developed for commercial populations are not always transferrable to a Medicaid population, and vice versa. Commercial firms in Tennessee noted that the state’s PCMH delivery system and payment model was developed for a Medicaid population and is not well suited for application in a commercial population. Conversely, Iowa had planned to build on Wellmark BCBS’ (Wellmark’s) VBP model for its Medicaid program, but the value index scoring system used to determine incentive payments in the Wellmark model does not adequately reflect the health care experience of a Medicaid population (see “Quality measure alignment” later in this section). Thus, although alignment of delivery system and payment

models across payers is desirable, states may need to offer flexibility in payment models to effectively engage the state's commercial payers in payment reform.

Medicare. In seven of the Round 2 Model Test states (Colorado, Connecticut, Delaware, Idaho, New York, Ohio, and Tennessee), officials noted the need to engage Medicare in the SIM Initiative. These state officials were concerned about not being able to transform the health care system without the involvement of Medicare, the primary payer for many high-cost residents. These state officials were also concerned about reaching the preponderance of care target for alternative payment methods without Medicare involvement; Medicare covers 14 percent to 18 percent of the population in the Round 2 Model Test states.

Provider participation

Securing provider participation in delivery system and payment reform models has also been challenging. Providers and stakeholders voiced a number of concerns:

Increased work load and risk, limited resources. Providers mentioned the increase in administrative burden and responsibility for care coordination involved in these models. In seven states (Delaware, Connecticut, Iowa, Ohio, Rhode Island, Tennessee, and Washington), providers voiced concerns about having to do more work and accept additional risk without additional resources. These providers reported receiving little to no increase in reimbursement, yet were at risk of being penalized for actions over which they have little to no control (e.g., whether patients fill prescriptions, comply with medication schedules).

Insufficient incentive payments. Incentive payments designed to change provider behavior, whether they are care coordination payments, bonuses for meeting certain milestones, or shared savings, were often viewed as insufficient.¹⁹ An Iowa provider noted that the relatively small incentive payment for her practice meant that a few thousand dollars had to be split among several physicians.

Disconnect between performance and incentive payments. A disconnect between the timing of performance changes and receipt of incentive payments was noted by providers in Colorado, Connecticut, Iowa, New York, Tennessee, and Washington.

Lack of payer support. Without commitments from payers, it is hard for providers to know how much or whether they will be reimbursed for their efforts. This lack of commitment is particularly difficult in states, such as New York, where payer participation is voluntary, and payers have discretion over the structure, amount, and timing of payments. Currently in New York, payers can elect not to offer APC practices new payments or they might offer smaller

¹⁹ Stakeholders associated incentive payments as being part of the SIM Initiative, given that they are elements of the delivery system and payment reforms. However, SIM funds are not allowed to be used for incentive payments to ensure voluntary participation and to avoid future sustainability issues.

payment amounts than providers or the state might like. In addition, payers might only offer payments to practices that have met the most advanced medical home level (Gate 3 of the APC model), rather than offering payments to practices that have attained some less-advanced level (e.g., Gate 1 or Gate 2 of the model). In New York, payers do not want to start paying practices new APC payments until practices have partially or fully adopted the APC model, whereas practices do not want to start adopting the APC care delivery model unless payers are willing to pay for the time and expenses involved in doing so.

In Colorado, SIM program administrators notified primary care practices of the extent of payer support only after the practices had applied to participate in the state's practice transformation initiative. The concern is that practices' expectations about the level of payer support to assist in the transformation expense may not match actual payer support. Hospitals in Iowa were skeptical that payment reform would actually occur—even though they had already changed the way they provided care and are hurting financially from reduced ER visits and admissions. Stakeholders shared concerns that provider support could wane in these states unless reimbursement was aligned with required performance changes.

Another layer to lack of payment support involves third-party administrators and their clients, self-insured employers. Frequently, self-insured employers want evidence of a return on investment before implementing or continuing delivery system and payment reforms. Stakeholders in Idaho mentioned that self-insured employers did not want to participate in PCMHs and their PMPM models. To do so, they wanted proof that participation in the models would reduce health care expenditures. While New York third-party administrators believed that their self-insured clients would only be interested in making APC payments if there was a clear return on investment in making the new payments, contractors for the state said that employers expressed interest in the reform when contacted directly. However, no new employers have signed on to make APC payments since these contrasting opinions came to light.

Lack of communication/education. Stakeholders in almost all the Round 2 Model Test states identified insufficient communication with providers as a challenge affecting participation in the SIM efforts. Providers have not traditionally tied payment to outcomes, so VBP requires a paradigm shift and educational programs to address the related issues. However, providers typically do not have sufficient time to engage with the educators.

EOC models are particularly technically complex and not easily communicated to community stakeholders. Continuing education for, and buy-in from, providers was described as a particular challenge in Ohio and Tennessee. In both states, most potential principal accountable providers participating in the focus groups were not even aware of their state's SIM Initiative or EOC payment models. This lack of awareness suggests the providers are not setting up the necessary systems to make these models effective. Stakeholders in both states thought more could be done to keep them informed as implementation progresses. For example, a Tennessee

stakeholder suggested that extensive and frequent communication with providers, using several modalities, is needed.

Varying levels of ability and readiness. Stakeholders in nearly all the Round 2 Model Test states noted that providers had different levels of ability and readiness to adopt the new delivery systems and payment structures. Ohio and New York identified as important technical and financial assistance for small and/or rural independent practices that may not be able to transform as easily as their larger and/or urban counterparts. Washington made similar comments with regard to its rural health clinics and urban FQHCs. Some states, such as Idaho and New York, were addressing this challenge by having payers offer providers multiple or layered options for participation.

Consumer engagement

Consumer engagement and empowerment is a central focus of the SIM Initiative in some Round 2 Model Test states, such as Connecticut and Delaware. Connecticut has made efforts to be inclusive and develop a robust governance structure that maximizes diverse stakeholder engagement. These efforts are reflected in the composition of all Connecticut work groups and committees—as well as in public meetings, targeted listening forums, and private meetings set up with the Project Management Office. Delaware engages providers, consumers, and payers in Delaware’s SIM Initiative through its DCHI committees. For example, health care payers are on all five DCHI committees. One stakeholder described the relationship with the state as “very collaborative” and said their “perspectives are absolutely [taken] into account. Whether it’s agreed with or not, there is a dialogue.”

In other states, SIM Initiative efforts are largely focused on health plans and health systems, with no clear plans for addressing consumer engagement. Consumer advocates in Ohio, New York, Tennessee, and Washington suggested that consumers’ perspectives are not adequately recognized in stakeholder forums and work groups, and that, in general, few opportunities exist for consumers to weigh in on the SIM efforts. Washington expressed concern about this issue and is searching for approaches to increase the direct participation of consumers. Despite Delaware’s focus on consumer engagement, there was still a clear need for engaging and educating consumers about the SIM Initiative to avoid its association with the ACA marketplace, which per consumer advocate stakeholders is viewed negatively by the state’s consumers. To address this need, the DCHI is hosting a series of six town hall meetings to engage and educate consumers beginning May 2016, and has scheduled television and radio spots for later the same year.

Integration with behavioral health

Integrating primary care and behavioral health services is part of nearly all the Round 2 Model Test states’ SIM Initiatives and is the cornerstone of the SIM Initiatives in Colorado and Rhode Island. States have identified several challenges related to the integration of these

services. Iowa noted the lack of a history of collaboration between medical providers and behavioral health and LTSS, due in part to separate accreditation processes of behavioral health services and LTSS, which are often carved out of Medicaid managed care contracts and managed through contracts with separate entities.

Stakeholders mentioned several possible reasons that make the integration of physical and behavior health care difficult. Colorado providers noted barriers to integration related to cultural differences in practice patterns between behavioral health and primary care (e.g., time allotted to see a patient varies tremendously between primary and behavioral health providers). In states beyond Colorado, some primary care providers are concerned about maintaining their autonomy and control in deciding a patient's care plan in an integrated setting. These providers want to be the "medical home" for patients, but not let additional providers into the practice or refer patients to care outside the practice. Other providers noted that some primary care providers are uncomfortable prescribing treatment for patients with behavioral health issues and shy away from screening for these conditions, leaving the task for someone else more appropriate for the job. To overcome such attitudes, which are counterproductive to integration, some states are using SIM funds to develop provider training and support programs to change the attitudes and behavior.

Integration of physical and mental health is predicated on an adequate workforce. Stakeholders in most states (Colorado, Delaware, Idaho, Iowa, Michigan, New York, Ohio, and Washington) noted workforce shortages of psychiatrists and other behavioral health professionals. New York and Ohio specifically highlighted shortages in pediatric behavioral health professionals which are particularly severe in rural areas in these states. Although the states have more behavioral health providers in metropolitan areas, rural residents often do not have the resources to travel for behavioral health care. Such care often requires multiple visits over an extended period.

Telehealth and E-visits (e.g., use of patient portals for patients to ask questions and providers to deliver follow-up care) are methods states are using to help alleviate primary care and behavioral health workforce shortages. However, without provider reimbursement, use of these services will remain limited. Colorado is one of the first states to have statutes and regulations guiding the use of and payment for telemedicine.

Another challenge is the low rate of patients, diagnosed in primary care with mental health conditions, who follow through on referrals to behavioral health providers. A Colorado consumer advocate noted that, even though campaigns and billboards in the state are designed to reduce stigma and encourage patients to follow through on referrals, referral follow through is still the "most profound barrier."

One of the greatest challenges for the integration of primary care and behavioral health, though, are the privacy laws that prevent sharing of behavioral health data. One Rhode Island stakeholder noted that, for the state’s Current Care system to be compliant with 42 CFR Part 2 (Confidentiality of Alcohol and Drug Abuse Patient Records) in sharing behavioral health information, providers must obtain consent from the patient every time they need to access data.

Quality measure alignment

Each Round 2 Model Test state is simultaneously conducting several efforts to transform primary care delivery and payment. Alignment among the different sets of quality measures each program requires providers to report may reduce provider burden. This potential burden would result from there being fewer quality metrics on which providers must report across efforts. Any such reduction in burden may increase provider participation and accelerate health care transformation.

All the Round 2 Model Test states are developing a set of core quality measures for use by all payers participating in SIM-related delivery system and payment models. These efforts, typically conducted by work groups with wide stakeholder involvement, faced several challenges in the development and spread of the core measure sets—including lack of data to produce the measures, diverse populations with varying health care needs, and lack of appropriate attribution procedures.

Source of data. No single source includes data from all payers and providers. Data typically come from provider EHRs, data aggregated by the provider and submitted through HIEs, and payer claims and encounter data. Providers use many different EHRs that collect and store data differently, thus complicating development of standardized definitions for numerators and denominators. Furthermore, not all MCOs provide complete, consistent claims and encounter data—these data are often missing payment information and details on procedures performed during inpatient stays and outpatient visits (e.g., laboratory services, follow-up visits).

Diverse populations. Some measures designed for a commercial population are not well suited for a Medicaid population. As previously mentioned, Iowa had planned to build on Wellmark’s VBP model for its Medicaid program, but the Value Index Score system used to determine incentive payments in the Wellmark model does not adequately reflect the health care experience of a Medicaid population. Current Wellmark measures assume patients are engaged with a particular primary care provider for a stable period of time, for example, which frequently does not happen for many Medicaid beneficiaries. Furthermore, measures related to behavioral health, LTSS, and social determinants of health would need to be added to adequately assess quality of care for Medicaid beneficiaries; but quality measures that are measurable, reliable, valid, and meaningful do not yet exist for certain provider types, such as HCBS providers.

Alignment with existing systems. Some existing data collection and analytic systems may need to be altered to accommodate changes in measures sets due to alignment; others may need to be abandoned for new systems. For example, MCOs will need to incorporate the new measures and tracking mechanisms into their existing proprietary performance measurement systems. However, Iowa MCOs were concerned that the current system would not be compatible with the aligned measure set, since the system could not identify MCO members by the providers they had seen.

Newer measure sets. Introduction of quality measure sets after the SIM alignment exercise (particularly those not developed in cooperation with Model Test states) can create additional, future work for the maintenance of alignment across measure sets or result in misalignment. For example, six Round 2 Model Test states (Connecticut, Delaware, Idaho, Iowa, Ohio, and Rhode Island) wanted to align their core quality measures with the Core Quality Measures released by CMS in February 2016. However, by the time these measures were released, many states had already done a lot of work on quality measure alignment.

Health information technology and data infrastructure

Health information exchanges. During the site visits, stakeholders identified a range of obstacles to achieving a single statewide HIE. One of the greatest challenges to any statewide health IT plan is the need to take account of existing private sector solutions. Many private payers and ACOs have developed their own solutions to the health IT needs of integrated systems and alternative payment methods, using their own sophisticated technology. Asking these payers and ACOs to adopt a less developed system for the sake of alignment across the state is a very major request. Rhode Island officials report that regulatory and policy limitations (e.g., privacy regulations) also run against a single statewide HIE and foster duplicative data reporting across the state.

Colorado, Delaware, Idaho, and Iowa do have statewide HIEs, but providers in these states see little value in joining the system. Connecting their EHRs to the HIE is costly, and in many cases, the HIE does not have much information beyond that already known to the practice. This lack of value in joining a statewide HIE is especially true for provider practices associated with large networks that already support data exchange on services obtained within the network. Iowa state officials consider the statewide HIE most useful as a platform to connect smaller, unaffiliated providers with major hospitals. However, that HIE has not attracted enough providers to become self-sustaining; the fee providers must pay to join the HIE is considered a major hindrance to participation.

Idaho's Statewide Healthcare Innovation Plan is working to connect providers to the IHDE and to support use of the data in PCMHs, but is facing some challenges. Like other states, many providers in Idaho have not seen the value of connecting to the IHDE. Although many providers in Idaho have EHRs, most are not participating in the IHDE or have chosen to view

data about their patients but not add their own data to the system. Most providers still receive follow-up specialist or hospital visit information via fax. Primary care providers in Idaho reported that the after-visit summaries they receive from the IHDE are often dozens of pages of mostly irrelevant information, with only a small amount of important information that is hard to find. Furthermore, many Idahoans receive much of their care from providers in Utah or Washington; these out-of-state providers do not have data in the Idaho HIE by definition.

All-payer claims databases. Besides clinical data from EHRs transmitted through an HIE, six Round 2 Model Test states (Colorado, Connecticut, New York, Rhode Island, Tennessee, and Washington) plan to use APCDs as a source of data for the quality measures and data analytics needed for care coordination and VBP. But these databases are at different stages of readiness for the purpose. The APCD in Connecticut is legislatively authorized but not yet fully functional. New York had hoped to draw data for its Scorecard from the state's HIE and APCD, but due to delays in front-end development and contracting for warehousing and analytics, the APCD is not yet functional. In the interim, the state has hired a contractor to generate a subset of the measures using claims data provided by payers participating in the APC. Currently, only Medicaid and qualified health plans are required to submit claims to the New York's APCD.

The March 2016 Supreme Court ruling in *Gobeille v. Liberty Mutual Insurance Company* concluded that states cannot require self-insured Employee Retirement Income Security Act plans to provide claims data to state APCDs. This ruling limits the usefulness of APCD data. Connecticut, for example, is relying on self-insured employers to provide employee information to supplement clinical data collected from providers. However, national employers currently using different data formats must pay someone to design a file that meets the state requirements for the APCD, which discourages voluntary participation.

Stakeholders also questioned the usefulness of the data reports from the EHR and APCD data systems. Many Tennessee stakeholders, for example, felt that the state's data reports would not be actionable unless providers have the knowledge and resources to interpret them. This lack of knowledge and resources was considered a particular challenge for small, private practices without the ability to train and hire data analysts.

Workforce shortages

Stakeholders in nearly all the Round 2 Model Test states noted shortages of health care providers and administrative staff. Workforce gaps were most often mentioned for primary care and behavioral health care providers, and in rural communities—which can complicate the collaboration needed for the new delivery systems. Iowa stakeholders noted that the few providers that do practice in rural areas often have long waiting lists, and rural-residing beneficiaries often do not have the resources to travel for services. In Michigan, stakeholders

noted a pent-up demand for certified CHWs and a need to fund the education and certification of this increasingly important health profession.

Despite these recognized needs, at the time of the 2016 site visits, neither Iowa nor Michigan was using SIM funds for workforce development. In New York, some external stakeholders felt that the state's SIM-related workforce development activities focused too narrowly on physician supply and saw a need for increased training of lower-level workers, who may well be called upon to perform care coordination tasks. Washington provider organizations particularly noted challenges in meeting the practice capacity needed to move to a VBP approach, given existing staffing limitations and other resource constraints.

Population health

A state's success in meeting the SIM Initiative population health requirement will likely depend on whether the definition and perspective being used by the state and its stakeholders matches that of CMMI. For example, a New York stakeholder noted that, if population health is defined in terms of managing populations of people with certain conditions such as diabetes or asthma, then New York is "already doing this"; but if population health is defined as improving the health of entire geographic populations, then New York "is behind."

A fundamental issue faced by several Round 2 Model Test states was getting everyone to agree on the definition and dimensions of population health for purposes of the SIM Initiative. Officials in six states (Colorado, Connecticut, Idaho, Iowa, New York, and Washington) noted the diverse perspectives on population health among the different stakeholders. For instance, some Washington payers viewed the population of interest as covered lives within their own commercial or Medicaid markets, whereas the state's ACHs viewed the population of interest more generally, as the state population divided by county.

At the time of the 2016 site visits, some states, were still working toward a common understanding of what "population health" means for their SIM Initiatives. For example, as part of its *Get Healthy Idaho: Measuring and Improving Population Health*, Idaho is defining the scope of population health. In Ohio and Rhode Island, in contrast, many local and regional public health activities were already being conducted to address priority conditions. At the time of the site visits, these states were working to determine how to align and augment these many activities within the SIM-related delivery system reform models.

In general, a population-based, community-applied approach to health care is a shift in thinking from the traditional delivery system-based model. Consequently, it may take some time to build the infrastructure to integrate the two approaches. For example, Iowa officials noted that the C3s need much more help than anticipated around coalition building and understanding the community-based model. Some stakeholders are apprehensive to participate in the C3 effort, due to concerns about the potential influence of reimbursement models or providers having to "give

up territory.” As another example, Ohio stakeholders remarked on the culture shift needed among physicians and hospitals to think more broadly than their medical services in order for the SIM Initiative to have an impact on population health.

Sustainability

Round 2 Model Test states are embedding the work of the SIM Initiative within already existing state offices and building internal expertise to support sustainability of the SIM models and strategies after federal SIM funds are gone. Nevertheless, stakeholders in many of the states expressed concerns about the sustainability of some components of their SIM Initiatives. For example, stakeholders described funding for the DCHI as uncertain and resting on the Center’s ability to prove its value to private sector payers. Idaho stakeholders said that whether providers would employ, and payers pay for, CHWs and CHEMS trained with SIM funds would depend on their early success in improving access in rural areas of the state.

More generally, the 3-year timeline of the SIM test period is considered by several state officials and stakeholders as too short for improvements in population health from these programs to be evident. But such evidence may be needed to secure ongoing support for the programs from other public and private sources. Stakeholders in Colorado, Idaho, Iowa, Rhode Island, and Washington expressed concern over the sustainability of the population health components of the SIM Initiative—including the C3 grants in Iowa, community health teams in Rhode Island, and ACHs in Washington.

3. Statewide Changes in Health Care Expenditures, Utilization, Care Coordination, Quality of Care, and Population Health

The SIM Initiative is intended to promote health care reform in the Model Test states. Many of the enabling strategies (e.g., health information technology [health IT] investment, workforce development) implemented under Round 2 of the SIM Initiative are available to all payers and providers statewide—and thus can potentially enhance the impact of other federal, state, and private sector initiatives within the state. To capture these effects, in future annual reports the RTI evaluation team will report statewide changes in health expenditures and utilization, care coordination, quality of care, and population health. Given that Round 2 Model Test states are early in their implementations, and relevant data are not yet available to measure SIM impacts, the RTI team summarizes the status, drivers of change, expected impact, and potential barriers for each of these categories of outcomes.

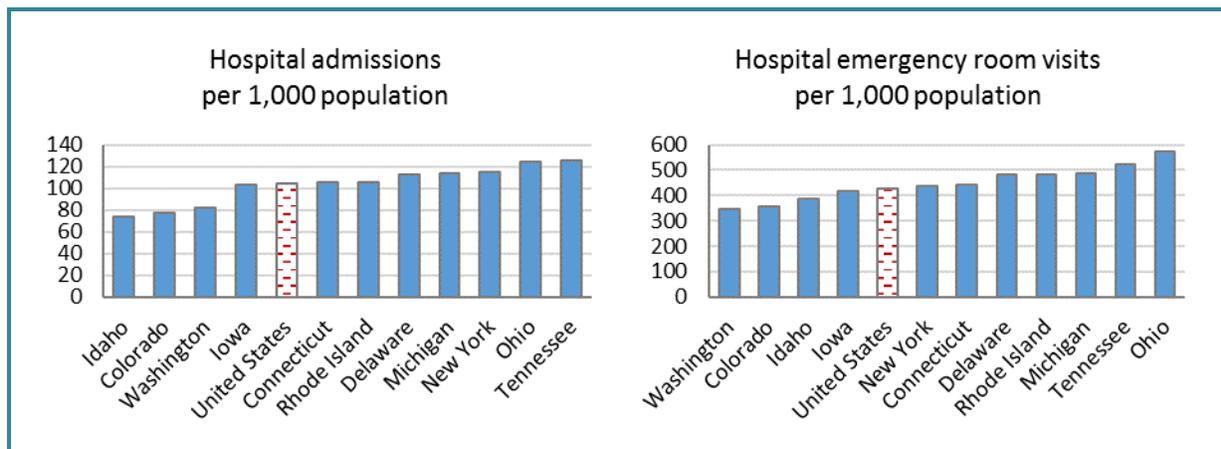
3.1 Health Care Expenditures and Utilization

One of the overarching aims of the SIM Initiative is to reduce health care spending. The Round 2 Model Test states plan to achieve this aim by increasing the efficiency and value of the health care system—thereby changing utilization patterns toward greater use of primary care, behavioral health, preventive, and social services; and/or fewer duplicative and unnecessary high-cost services (e.g., avoidable hospital admissions and emergency room [ER] visits).

3.1.1 Status

Figure 3-1 shows rates of hospitalization and ER visits for the 11 Round 2 Model Test states and the United States in 2014, based on data from the American Hospital Association. The use of high-cost services varied markedly by state. The rate of hospital admissions was 69 percent higher in Tennessee than in Idaho, and the rate of ER visits was 65 percent higher in Ohio than in Washington. Only four states (Idaho, Colorado, Washington, and Iowa) had both hospital admission rates and hospital ER visit rates lower than the national average.

Figure 3-1. State Innovation Model Initiative Round 2 Model Test states' hospital admission and emergency room visit rates, 2014



Source: American Hospital Association (2015)²⁰

3.1.2 Drivers of change, expected impact, and potential barriers

All the delivery system and payment reform models, enabling strategies, and policy levers being implemented under Round 2 the SIM Initiative are designed to increase the efficiency and value of the states' health care systems. At least four states (Connecticut, New York, Rhode Island, and Tennessee) recognized the difficulty in realizing actual reductions in the total cost of care, and instead, targeted a reduction in the rate of spending growth during the SIM Round 2 test period. Iowa officials noted that some population health improvement projects addressing the social determinants of health may actually increase costs initially, and expected no cost savings during the 3-year test period—that cost savings would come in later years with lower chronic and acute disease prevalence. All 11 states expected to see changes in utilization patterns—greater primary care, behavioral health, and preventive service use and lower hospital admissions, re-admissions, and ER visits.

Stakeholders noted several potential barriers to reaching health spending and utilization targets—including primary care and behavioral health provider shortages, low provider reimbursement levels, excess capacity in certain resource-intensive specialty services, the existence of significant rural populations and low-volume providers, and the short test period. Colorado and Delaware stakeholders also noted the misalignment of incentives in some health care systems, in which primary care providers (PCPs) are tasked with reducing overutilization of high-cost services when significant profits are made by the health system from these same

²⁰ American Hospital Association (AHA). (2015). *1999–2014 AHA Annual Survey* [Special data request]. Retrieved from <http://www.ahaonlinestore.com>.

services. For example, a health system can get higher reimbursement for the same service if that service is provided in the ER rather than in a physician’s office.

Furthermore, changing ER visit patterns in Medicaid will require Medicaid beneficiaries to change their approach to seeking care—particularly reducing their reliance on the ER for nonemergency health care. Medicaid beneficiaries participating in consumer focus groups saw the ER as an acceptable alternative to waiting to see their usual PCP during office hours. Thus, one approach to lowering health care expenditures could be getting Medicaid patients to use ER services more appropriately. Provider focus group participants noted that, to change patients’ inclination to go to the ER requires building a relationship and trust. However, the time investment needed to do so can be prohibitive, especially among Medicaid beneficiaries who go on and off the program.

3.2 Care Coordination

A key aim of health care transformation in the United States is a shift from encounter-based care delivery to patient-centered, coordinated care. Care coordination requires a team-based approach in which all participants in the patient’s care—patient, PCP, specialists, and community-based service providers—work together to meet the patient’s care needs and preferences, providing access to comprehensive, quality, and safe care.²¹

3.2.1 Status

Stakeholders characterized the status of care coordination in the Round 2 Model Test states as mixed. For example, a provider organization in Tennessee described care coordination in the state as “disjointed” and “hit-or-miss”—meaning that care coordination was being done well only in limited areas (e.g., Memphis community health centers, academic medical centers), or for limited groups of patients (e.g., high-risk individuals).

Consumer focus group participants within Tennessee and the other Round 2 Model Test states corroborated this view. Consumer participants were primarily Medicaid beneficiaries but included state employees in Delaware and New York. Some Idaho participants described being part of a care team, having care plans or care coordinators, or discussing care goals with their provider; but others expressed frustration with their providers not knowing about or being up-to-date on their needs, medical history, or other services; and not communicating with one another.

²¹ This definition of “care coordination” is consistent with the Agency for Healthcare Research and Quality’s website and the Institute of Medicine’s *Crossing the Quality Chasm* definitions, but is closest in wording to that of the National Quality Forum. The wording has been altered slightly here to fit the report at hand. See National Quality Forum. (2013). *NQF-endorsed™ definition and framework for measuring care coordination*. Retrieved from <http://nursingworld.org/Archive-Doc-Vault/Care-Coordination-Panel-Docs/background-docs/Jun-4-Mtg-docs/NQFCare-Coordination-Definition-Framework.pdf>.

The consumers who described themselves as part of a care team were often those who received care at large medical systems or had multiple chronic conditions.

Provider experience with tools to assist with care coordination varied. Providers in Rhode Island and certain regions of New York said they are successfully implementing care coordination techniques. PCPs participating in focus groups in Michigan reported that they had been spending increasingly more time over the past few years communicating with specialists and other providers about individual patients, and are relying more and more on electronic health records (EHRs) to share patient data. However, some providers in Tennessee had not adopted EHR systems and said they have no plans to do so. Furthermore, only participating PCPs in Iowa and Ohio noted having dedicated care coordinators in their practices.

3.2.2 Drivers of change, expected impact, and potential barriers

All the delivery system and payment reform models, enabling strategies, and policy levers being implemented under Round 2 of the SIM Initiative are designed to improve care coordination. When asked about the primary drivers for coordinated care under their state's SIM Initiative, stakeholders most often cited the delivery system and payment models. For example, care coordination both between PCPs and specialists and between primary care and other community-based services is a primary focus of patient-centered medical homes (PCMHs). Practice transformation to the PCMH model was listed by stakeholders in Connecticut, Idaho, Michigan, Ohio, and Tennessee as the primary driver of improvements in care coordination expected under their SIM Initiatives.

However, stakeholders in these states noted that care coordination within and across practices relies heavily on statewide health IT and each practice's ability to seamlessly share information about patients. These stakeholders, therefore, also listed SIM-funded enhancements to health IT infrastructure, practice transformation facilitation activities, and value-based payment as important facets of these models in enabling and incentivizing the desired improvement in care coordination.

Stakeholders also noted several measures the states planned to use to provide evidence of success in improving care coordination—including process measures (e.g., increased counts of practices designated as PCMHs, providers connected to the statewide health information exchange) and outcomes measures (e.g., reduced rates of hospital re-admissions and ER visits for nonemergency care).

Stakeholders described numerous barriers to achieving the expected improvement in care coordination under Round 2 of the SIM Initiative, including, but not limited to, the following:

- workforce shortages and lack of trained personnel
- technical, financial, and legal requirements for secure sharing of patient data

- cultural differences between primary care and behavioral health practices
- delays in implementing effective financial incentives
- lack of referral networks for resources such as dentists, dieticians, and social workers
- large number and range of providers and payers in the state to coordinate
- time it takes to resolve all these issues

The report describes these challenges in greater detail in *Section 2.9.2*.

3.3 Quality of Care

Another overarching aim of the SIM Initiative is to transform the health care system to deliver better quality care. The Institute of Medicine has defined quality of care as the degree to which health services increase the likelihood of desired health outcomes and are consistent with current professional knowledge.²² Quality of care measures typically show discrepancies between the current standards of care and actual practice. New delivery system models require participating practices to report on select quality measures, and payment reform models base incentive payments on the practices meeting targeted levels of these measures.

3.3.1 Status

Stakeholder from several states assessed the level of the quality of care in their state as high. Iowa’s stakeholders expressed some of the strongest positive views. Iowa’s stakeholders viewed high-quality care as a pre-SIM strength of the state’s health delivery system. Nearly all of Iowa’s Medicaid beneficiaries participating in the focus groups said they have a usual source of primary care; a majority expressed satisfaction with their care and that it is high quality. Most Delaware consumer focus group participants ranked their providers between 7 and 10 on a 10-point scale (with 10 as the best score). These consumers said they appreciate that their providers take time to talk with them about their medication and health.

While stakeholders were generally positive about the quality of care in their states, there were exceptions. Stakeholders in Idaho and New York noted that, compared to other states, their states ranked low in health care quality. New York stakeholders additionally noted that the quality of care was not commensurate with the high, health care spending in the state. Ohio and Rhode Island stakeholders characterized the quality of care as variable in their states. Ohio has both nationally and internationally known health care providers—such as the Cleveland Clinic, the University Hospitals of Cleveland (a network of hospitals affiliated with Case Western Research University), and Ohio State University Wexner Medical Center—but also has a number of small practices in the more rural parts of the state that are less connected to the latest medical advances. Although, in general, the quality of care was favorably viewed in Rhode Island,

²² Institute of Medicine. (1994). *America’s health in transition: Protecting and improving quality*. Washington, DC: National Academies Press.

stakeholders believed that access to and quality of behavioral health care could be significantly improved.

Consumers participating in focus groups had mixed perceptions of the care they received. The most common complaints were difficulty making appointments, long wait times, and feeling rushed through their appointments. In Colorado, consumer focus group participants also noted limited ability to contact providers outside an appointment for quick questions. Provider focus group participants noted the “depersonalization” of care resulting from increased documentation requirements and growing reliance on health IT. Providers felt they were being asked to do progressively more without the flexibility of more time to spend with each patient. PCPs also noted difficulty finding specialists that would accept Medicaid patient referrals.

3.3.2 Drivers of change, expected impact, and potential barriers

Performance requirements for delivery system certification and health outcome targets for receiving incentive payments were noted by stakeholders as the primary drivers of improvements in the quality of care. All Round 2 Model Test states had developed a common set of measures for assessing quality of care. These measures include compliance with recommendations for various screenings, childhood immunizations, and well-child visit schedules; the prevalence of potentially avoidable outcomes, such as low birthweight infants; weight assessment and counseling; and various measures for the management of chronic diseases, such as blood pressure control for hypertension and adherence to medication guidelines. The states are tracking the measures on a quarterly, biannual, or annual basis.

Stakeholders in some states (e.g., New York) believed that improvements in the quality of care were “early wins”—that is, that positive changes would be achievable in the early years of implementation. In other states, stakeholders noted that the short timeframe (e.g., Idaho and Rhode Island), delays in introducing value-based payments (e.g., Iowa), or difficulties in implementing a common scorecard (e.g., Connecticut) make it unlikely that statewide improvements will occur during the 3-year test period.

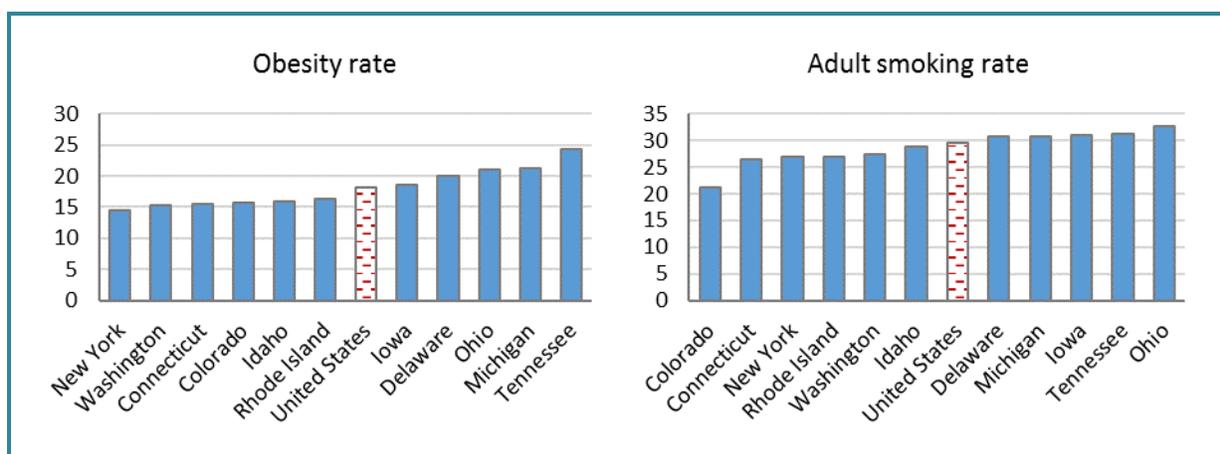
3.4 Population Health

Improving population health, variously defined, is one of the three goals of all models and strategies being tested under Round 2 of the SIM Initiative. Each Model Test state must develop a population health plan that (1) integrates improvements to population health into its delivery system and payment reforms and (2) maximizes the impact of various state and local activities on population health, quality of care, and health care costs. CMMI categorizes potential activities for the population health plans into three “buckets”: traditional clinical approaches, innovative patient-centered care, and broad community-wide approaches. In addition to describing strategies to improve a state’s self-identified priority areas, the population health plan may also identify population health goals and metrics to monitor progress toward the goals.

3.4.1 Status

The relative ranking of the Round 2 Model Test states on a range of population health measures varied markedly. On two of the SIM Initiative priority areas—obesity and tobacco use—six states (Colorado, Connecticut, Idaho, New York, Rhode Island, and Washington) had crude prevalence rates less than the national average in 2014. The other five states (Delaware, Iowa, Michigan, Ohio, and Tennessee) had higher rates (*Figure 3-2*).

Figure 3-2. State Innovation Model Initiative Round 2 Model Test states' adult obesity and smoking rates, 2014



Source: Centers for Disease Control and Prevention (2015)²³

The status and content of the populations health plans differed across the Round 2 Model Test states. However, all states are coordinating with and building on existing efforts (e.g., Idaho's *Get Healthy Idaho*, Iowa's Community Care Team Pilot). New York, Rhode Island, and Tennessee were still working on their SIM-related population health plans at the time of the 2016 site visit. In Ohio, no population health efforts were being financed with SIM funds, but the state's efforts in this area were being guided by the SIM Operational Plan.

In addition to addressing the three SIM Initiative priority areas of diabetes, obesity, and tobacco use, the Round 2 Model Test states were adding their own statewide priority areas. For instance, health equity and access to care are priorities in Connecticut, Idaho, and Tennessee; mental health and substance use are priorities in Colorado and Rhode Island.

In designing interventions, some states are letting community coalitions choose among identified priority areas, based on the greatest needs of their community. For example, Delaware's 10 Healthy Neighborhoods will each create and implement a 3-year plan of locally

²³ Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. (2015). *BRFSS prevalence & trends data*. Retrieved September 10, 2016, from <http://www.cdc.gov/brfss/brfssprevalence/>.

tailored solutions to address one or more of four statewide population health priorities (see **Section 2.4** for more details). Iowa’s Community Care Coalitions (C3s), Washington’s Accountable Communities of Health, and regional entities in other states will identify local health priorities, align them with those of their state, and develop and implement locally driven health improvement projects to address those priorities.

3.4.2 Drivers of change, expected impact, and potential barriers

The models and strategies designed to integrate clinical, public health, and community-based services were mentioned most often by stakeholders as the primary drivers of expected improvements in population health in Round 2 of the SIM Initiative. Practice transformation under delivery system and payment reform models were also specifically cited as primary drivers of population health improvements by stakeholders in Iowa, New York, Tennessee, and Washington. These stakeholders believed that providers in transformed practices would be more likely to emphasize preventive care, discuss strategies for healthy lifestyles with patients, and be aware of and refer more of their patients to community-based programs and social support services. One payer from Washington noted that focusing on each individual positively affects population health in the aggregate.

For the most part, as of the 2016 site visits, the Round 2 Model Test states had not identified a specific timeline for impacts on population health of the SIM-related models and strategies. Colorado officials noted that, in the short term, they expected to see only a small impact and mostly in saturation measures for SIM-related population health activities—such as number of providers who complete designated courses on behavioral health and substance use screening, and number of SIM-funded local public health agencies collaborating in a coalition with community partners. Iowa stakeholders voiced uncertainty about whether to expect improvements in population health during Award Years 2–4. The Iowa stakeholders cited delays in the implementation of value-based purchasing and the limited scope of the C3 initiative as reasons for not expecting improvements. However, stakeholders also recognized that Iowa’s pre-SIM population health initiatives may increase the likelihood of improvements in population health during Award Years 2–4.

The major potential barriers to achieving meaningful improvements in population health during Award Years 2–4, as noted by stakeholders, included inadequate provider education, particularly on behavioral health issues, screening, and treatment; lack of adequate data to identify and prioritize population health needs; limited scope and funding of the SIM-funded population health interventions; and the shortness of the 3-year timeline.

Stakeholders in Colorado, Ohio, and Rhode Island mentioned that inadequate provider education may hinder the progress their states make in improving population health. Colorado stakeholders identified greater provider education around behavioral health as a necessary

element for Colorado’s efforts to increase population health to be effective. Similarly, Rhode Island stakeholders focused on behavioral health education. In Rhode Island, whether behavioral health providers have the skills and mindset to meaningfully participate in a system that promotes population health is uncertain. Ohio stakeholders described a need for a large cultural shift among physicians and hospitals, such that these providers view health more broadly, not just as the medical services they provide.

Ohio and Washington identified data as concerns in their efforts to improve population health. In Ohio, differing data sources will make operationalizing common population and clinical measures difficult. Similarly, stakeholders in Washington expressed a need for health IT enhancements that would allow different data systems to be connected to clinical data, so that new, informative data and measures could be produced.

Limited scope and funding may curtail population health advancements in Colorado, Connecticut, Iowa, and Ohio. Stakeholders in Colorado mentioned that not a lot of SIM-funding is being allocated to population health work in the states. Furthermore, there were concerns about sustainability of any population health efforts beyond the SIM award years. Connecticut mentioned the need to leverage other resources beyond SIM funds to increase the likelihood of improving population health. Inadequate financial resources also were a concern for Ohio stakeholders, who also identified limited scope as an issue. They described the population health efforts of the state as “theoretical” and doubted that the state’s effort would have success at the community level. Iowa stakeholders described the scope of the C3s, the entities charged with aligning priorities of the communities’ Community Health Needs Assessment and Health Improvement Plans, as limited.

Furthermore, because most of the Round 2 Model Test states are implementing population health measures on a substate level, changes may not be perceptible in statewide measures.

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4. Highlights from Site Visits

This chapter reports on highlights from the site visits to each of the Round 2 Model Test states. This chapter includes findings based on qualitative data collected through June 30, 2016. *Appendixes A–K* contain detailed site visit reports for each of the Round 2 Model Test states.

4.1 Colorado

The goal of Colorado’s SIM Initiative is to improve the health of Coloradans by providing access to integrated physical and behavioral health care services in coordinated community systems, with value-based payment (VBP) structures, for 80 percent of Colorado residents by 2019. Colorado has a high prevalence of behavioral health conditions in the general population, so the state’s decision to pursue integration of behavioral health in primary care as the hallmark of its SIM Initiative was uniformly lauded by state officials, providers, and consumer advocates. Colorado is adopting the following to meet its SIM goal:

- ***Practice transformation.*** Colorado will recruit 400 primary care practices over 3 years to transition to integrating physical and behavioral health. Primary care practices will receive practice transformation and clinical health information technology (health IT) facilitation, access to financial capital to support transformation activities, and collaborative learning.

Complementing the focus on primary care practice transformation to improve integration, Colorado will fund community mental health centers (CMHCs) to provide or co-locate primary care for their patients; these CMHCs will be known as bidirectional health homes. As of the 2016 site visit, the first group of 100 primary care practices were chosen for transformation assistance from 179 practices that applied, and 17 organizations (to be known as Practice Transformation Organizations) were chosen to work with practices towards 10 key milestones of transformation. Four CMHCs were chosen to become bi-directional health homes from 11 that applied.

- ***Payment reform.*** Colorado will work with major commercial health plans in the state and Medicaid to shift from fee-for-service (FFS) payment arrangements toward more VBPs. Much of Colorado’s SIM payment reform strategies build upon payment reform implemented through Colorado’s participation in the Comprehensive Primary Care initiative (CPCi). Many site visit interviews noted that CPCi was critical to building trust among the state, primary care practices, and payers; and the interviewees viewed the collaboration among payers that arose from CPCi as critical to successful implementation of payment reform in the state’s SIM Initiative.
- ***Primary Care Transformation.*** Six of the nine major private payers in Colorado, as well as Medicaid, agreed to reimburse SIM participating practices using a VBP approach of the payer’s design. All 100 practices will receive some form of VBP by at least one participating payer. After applying to participate, the SIM office notified practices which payer(s) indicated they would support the practice with a VBP. The

participating payer decided on the type and amount of VBP that would be made to the practice. Some state official interviewees noted that the approach of applying to participate before knowing the details of VBP caused confusion. Some primary care practices had expectations about the amount of additional reimbursement needed to undergo transformation that may not match the actual reimbursement amounts payers offered.

- ***Bidirectional health homes.*** Private payers and Medicaid are not yet engaged in a specific VBP strategy for bidirectional health homes, the way payers are engaged in VBP for the SIM-participating primary care practices. One provider described as a missed opportunity.

A key concern for payment reform is Colorado's ability to meet the goal of having 80 percent of residents in an integrated physical/behavioral health system supported by VBPs. Some site visit interviewees noted the importance of how the state counts those touched by the system and how value-based is defined in predicting whether or not reaching 80 percent is feasible. Others questioned the state's ability to reach that many people irrespective of the definitions used, especially if Medicare does not participate.

- ***Population health.*** Colorado's focus is on community engagement, reducing stigma, and increasing access to behavioral health resources through (1) grants to local public health agencies and community organizations, to build community coalition and support activities in stigma reduction and promotion of best practices in mental health screening; (2) development of provider education tools on screening for behavioral health conditions in primary care; and (3) deployment of Regional Health Connectors—individuals hosted in a local public health agency or other community-based organization—who will connect primary care practices to community partners that can support practices' in their behavioral health integration activities and in any other needed coordination activities. At the time of the 2016 site visit, SIM strategies and goals around population health were in the nascent phases of development and not well understood by many site visit interviewees.
- ***Health Information Technology.*** Colorado will develop a platform (known as quality measures reporting tool + [QMRT+]) for acquisition, processing, and aggregation of patient-level clinical and claims data to provide practices, payers, and other stakeholders with summary information on quality and costs of care. As of the 2016 site visit, a vendor had not yet been selected to build QMRT+. Many stakeholders interviewed considered building this platform to be a monumental undertaking, and the state is sensitive to the need for the platform to be sustainable after Award Year 4 ends. The state will also develop a telehealth strategy that lays the groundwork for telehealth expansion throughout Colorado.

The Colorado SIM Director sits in the Governor's Office, and day-to-day operations are carried out by the director and a small team of full-time staff. The SIM Director has the primary responsibility for regularly updating representatives from the Governor's Office on SIM implementation and progress. Placement of staff within the Governor's Office was not uniformly

well-received,, with some questioning why all SIM staff are not headquartered within an existing state agency that is already extensively involved in the SIM Initiative. Several interviewees noted that there might have been efficiencies gained in locating the SIM office within a pre-existing administrative structure.

Key state agency partners in the state’s SIM Initiative include the Department of Health Care Policy and Financing, Department of Public Health and Environment, Office of Behavioral Health in the Department of Human Services, E-Health Commission, and Department of Insurance. Nonstate agency partners include the University of Colorado, Colorado Behavioral Health Council, and Colorado Health Institute. Each of these organizations is tasked with carrying out key SIM implementation activities—such as designing the primary care practice transformation activities, overseeing the Regional Health Connector program, and operationalizing the CMHC bidirectional health homes.

In addition to these partners, the Colorado SIM Initiative created eight work groups²⁴ to operationalize delivery system reform, payment models, and enabling strategies. The work groups report directly to a Steering Committee, which comprises the work group chairs and co-chairs, and interfaces with the SIM Advisory Board. While the workgroups were generally positively received, stakeholders expressed some mixed feelings about the administrative structure—with some interviewees saying the SIM Advisory Board is not being asked to provide advice and guidance on implementation, and others being unclear as to who the ultimate decision maker is (the SIM office, the Governor’s Office, the SIM Advisory Board, or the work groups).

Care coordination was viewed as critical to integration efforts. Across all groups of stakeholders interviewed, success in coordinating care was described variously as, “We want the right services offered at the right time for the patients who need them,” and no provider will be able to say, “I can’t help you,” to a patient, because they will not get paid for it. Patients will be connected, as needed, to the services and supports to ensure good health. Despite having relatively clear and homogeneous concepts of what success would look like, stakeholders did not show a clear understanding about how care coordination would be measured.

Further, some state officials, payers, and providers—although hopeful and positive—were aware of significant challenges to coordination and integration. Primary care and behavioral health provider shortages, and cultural differences in practice patterns between behavioral health and primary care (e.g., time spent with a patient), were noted as key issues in achieving integration of behavioral health and physical health. Payment reform was also viewed as a precondition for pursuing models of alternative access and integration—with global or capitated payment expected to eliminate the practice of only providing reimbursable services.

²⁴ Consumer Engagement, Evaluation, Health Information Technology and Data, Payment Reform, Policy, Population Health, Practice Transformation and Service Delivery, and Workforce.

Colorado expects improved quality of care due to integration and will monitor quality through collection and analysis of quality of care measures. Consumer focus group participants were generally satisfied with the care they were able to obtain from their primary care provider. Primary care and behavioral health provider focus group participants, in contrast, noted a definite gap in quality—that primary care providers shy away from screening for behavioral health concerns, because they are unsure how to treat such conditions if screening identifies them. Some providers described this mindset (leaving the task for someone else more appropriate for the job) as counterproductive to true integration of physical and behavioral health. Some state officials also noted that, if implemented successfully, the SIM integration activities have the potential to change this mindset and provide primary care practitioners the resources to successfully screen patients, treat them if able, or refer them to behavioral health providers for more intensive treatment.

Colorado expects increased utilization of primary and behavioral health care services and reductions in high-cost services, such as emergency room (ER) visits and general and psychiatric inpatient admissions. At least one provider noted that there had been a missed opportunity to focus on high-utilizers of health care. Most site visit interviewees did not mention concerns about the current costs of care in Colorado, and almost none discussed explicit goals to reduce costs of care. However, one payer and one state official did note that, if the SIM Initiative is successful, payers can expect some reduction in the total cost of care, based on past experiences with accountable care initiatives and the impacts of care coordination strategies on reducing high-dollar utilization, like ER visits. The state will monitor trends in utilization and cost of care.

SIM is one of several federal initiatives in the state (other initiatives include CPCi, Transforming Clinical Practice Initiative, and Evidence Now Southwest), and private payers have numerous practice transformation efforts under way with many of their provider networks. State official and payer interviewees noted that “innovation fatigue” is not uncommon, and these interviewees emphasized the need for alignment, coordination, and simplification within the SIM Initiative with other statewide initiatives already under way.

In the first year of implementation, Colorado has enrolled 100 primary care practices and connected each with payers who will reimburse them with VBPs, selected four CMHCs that began to plan for integration, and rolled out a number of population health and health IT activities. As Colorado continues to implement its SIM Initiative, the federal evaluators will follow many areas: (1) alignment, coordination, and simplification within the SIM Initiative and with other statewide initiatives; (2) alignment of expectations between primary care practices and payers, so as not to lose the support of either group in supporting integration and practice transformation; (3) operationalizing the vision of the QMRT+ platform; and (4) communication to stakeholders regarding the SIM Initiative’s population health strategies.

4.2 Connecticut

Connecticut’s SIM vision is to establish a whole person-centered health care system that improves community health and eliminates health inequities; ensures superior access, quality, and care experience; empowers individuals to actively participate in their health and health care; and improves affordability by reducing health care costs. To achieve these goals, the state plans to implement an array of complementary health care delivery and payment reform strategies. The proposed models and their components include the following:

- **Population Health Plan.** The state’s plan
 - establishes a proof of concept model for Prevention Service Centers to offer evidence-based community preventive efforts with primary care providers, and
 - develops a comprehensive plan for Health Enhancement Communities to foster coordination and accountability among community organizations, health care providers, schools, and other entities—to improve health and social determinants of health in geographic areas with the greatest disparities.
- **Advanced Medical Home Program.** The Advanced Medical Home (AMH) program provides support to facilitate practice transformation toward National Committee for Quality Assurance medical home recognition.
- **Community and Clinical Integration Program.** The Community and Clinical Integration Program (CCIP) provides technical assistance (TA) to Advanced Networks and Federally Qualified Health Centers (FQHCs) to enhance capabilities in supporting individuals with complex needs, reducing health equity gaps, and integrating behavioral and oral health.
- **Person-Centered Medical Home Plus Program.**²⁵ The Person-Centered Medical Home Plus (PCMH+) rewards providers in Advanced Networks or FQHCs with shared savings for improving access, care coordination, health outcomes, and health equity. The PCMH+ model includes only upside (and no downside) risk.
- **Value-based insurance design.** The state will encourage adoption of value-based insurance design (VBID) by Connecticut employers—by convening business groups and employers to develop VBID prototypes and tool kits, and creating a learning collaborative to disseminate best practices.
- **Workforce development.** The state will focus on developing the community health worker (CHW) workforce and incorporating CHWs into primary care teams or preventive service provision.

²⁵ During the reporting period (February 1, 2015–June 30, 2016), PCMH+ was known as Medicaid Quality Improvement Shared Savings Program (MQISSP). The information regarding PCMH+ included in this report relates to program details and stakeholder understanding of MQISSP.

- ***Quality measurement alignment.*** The state will develop a
 - core quality measurement set,
 - common cross-payer measure of care experience tied to VBP, and
 - common provider scorecard.
- ***Health information technology.*** The state will use health IT to
 - develop advanced payer and provider analytic capabilities,
 - standardize approach to clinical information exchange,
 - develop technology to enable development and use of multi-payer core measure set and common provider scorecard, and
 - implement policy that allows for enhanced use of all-payer claims database (APCD) (e.g., provide detailed analytics at individual level).
- ***Consumer Engagement.*** The state will conduct consumer outreach and education through public meetings, focus groups, and listening tours.

Connecticut’s SIM Initiative is administered by the Program Management Office, located within the Office of the Healthcare Advocate. The Program Management Office reports to the Lieutenant Governor, who plays a key oversight role. Connecticut’s SIM Initiative is guided by a steering committee as well as eight work groups and four design groups that serve in an advisory role to the Program Management Office. Each group focuses on developing a particular element of the SIM Initiative, and includes a variety of stakeholders with relevant interests and expertise. State agencies—including the Department of Social Services, Department of Public Health, Office of the State Comptroller and Department of Mental Health and Addiction Services—also participate in the SIM Initiative.

Stakeholders were generally satisfied with the SIM governance structure, noting that the state has gone to great lengths to ensure diverse multi-sector stakeholder representation and engagement on SIM work groups, and has been very receptive to stakeholder feedback. Challenges pertaining to the governance structure include limited administrative capacity in the Office of the Healthcare Advocate, limited staff resources due to a state hiring freeze, and inefficiencies in workgroup processes.

Beyond work groups and committees, the state engages and educates stakeholders on the SIM Initiative through meetings, symposiums, and listening forums. Connecticut has a very engaged Consumer Advisory Board to ensure the consumer perspective is incorporated into all facets of SIM design and implementation. For example, the state responded to consumer concerns that PCMH+ will incentivize providers to limit services by developing the upside risk-only program and delaying the launch of PCMH+ to foster greater consumer support.

During the May 2–4, 2016 site visit, stakeholders—including state officials, payers, purchasers, consumers, and providers—offered their perspectives on Connecticut’s current health care system, the state’s SIM objectives, and existing infrastructure that will support the SIM Initiative.

Stakeholders describing the context for health care reform in Connecticut noted how strengths and weaknesses of the health care system have shaped the SIM Initiative. Many stakeholders agreed that successful, state-led initiatives such as the Medicaid Person-Centered Medical Home program will provide a strong foundation for the Advance Medical Home and PCMH+ initiatives, as providers have experience with similar delivery and payment transformations. Similarly, stakeholders viewed the state employee VBID program as a strong starting point for the SIM VBID initiative and an opportunity to expand an existing and successful program. SIM activities will allow the state to enhance such initiatives by incorporating greater care coordination elements and expanding to new populations. Many stakeholders saw value in the state’s decision to align Medicaid payment reform under the SIM initiative (PCMH+) with the emergence of the Medicare Shared Savings Program and commercial shared savings programs occurring throughout the state accountable care organizations (ACOs). Stakeholders were optimistic this alignment will reduce the burden for PCMH+ providers, who may already be participating in shared savings arrangements with other payers and be familiar with new processes.

However, stakeholders also voiced concerns about the implementation of Connecticut’s SIM award. The state has faced resistance to PCMH+ from consumer advocates, who cite concerns of underservice and lack of transparency stemming from the state’s prior experiences with Medicaid managed care. Stakeholders also identified lack of a health IT infrastructure and the state’s stark health disparities as additional challenges to the SIM Initiative. Finally, the state’s severe structural budget deficit was noted as an underlying concern that may impact the ability of state agencies to participate in certain aspects of the SIM Initiative and adequately staff the project, due to state employee layoffs and a hiring freeze.

Connecticut has designed several complementary health care service delivery and payment reform models and health improvement strategies to transform clinical practice and improve linkages with community services that impact health. The PCMH+, Community and Clinical Integration Program, and AMH initiatives are intended to support organizational and practice-level transformation through TA and payment reform. The state’s population health strategy is intended to strengthen community-clinical linkages and promote disease prevention. VBID is intended to engage consumers in their health care. Health IT, quality measurement alignment, and workforce development strategies are designed to foster the success of the core delivery and payment reform strategies.

Stakeholders shared that high health care expenditures are a major concern for the state. Through the SIM Initiative, Connecticut aims to achieve a one percent to two percent reduction in the annual growth rate of health care costs. Stakeholders cited the state's growing budget deficit, decreased incentives for hospitals to compete on costs due to consolidation, and a Medicaid FFS system that rewards volume over value, as important challenges. However, stakeholders were optimistic that SIM strategies—including PCMH+, AMH, and VBID—will impact expenditures by incentivizing high-quality care, increasing care management, and increasing access to preventive services, to avoid expensive ER visits and reduce unnecessary specialty services.

Throughout interviews, stakeholders acknowledged a pressing need to improve care coordination, particularly to support primary and behavioral health integration and to include a consideration of social determinants of health. Consumer and provider focus group participants expressed this need; those discussions also revealed that consumers do not usually have care plans or care coordinators/managers, or receive team-based care. Consumers complained of receiving care in an uncoordinated and fragmented system, noting that follow-up appointments are often with different providers who are not aware of prior visits.

Accordingly, care coordination is an important focus area, and Connecticut's SIM Initiative includes several strategies aiming to improve care coordination. The AMH program includes improved care coordination as a specific aim, and stakeholders identified PCMH+ as another important care coordination program since it will build on the Department of Social Services' existing Person-Centered Medical Home model by incorporating new enhanced care coordination activities and provider reimbursement strategies. The state will also address care coordination by delivering TA to providers through Community and Clinical Integration Program, employing CHWs to provide care coordination services for vulnerable and complex populations, and identifying a technology solution that enables timely and secure information exchange.

Health IT and health information exchange (HIE) were highlighted as areas of much needed improvement in the state. Stakeholders viewed the SIM Initiative as a catalyst and enabling mechanism for health IT, which is considered an enabler of payment and delivery system reforms. The SIM Initiative hopes to develop a health IT strategy that facilitates quality measure production and data exchange. However, stakeholders found health IT to be the most problematic component of the SIM award and agreed that Connecticut's health IT strategy is nascent in comparison with that of other states. The quoted range of concerns includes lack of vision, communication challenges among partners, and infrastructure limitations. Another health IT challenge several stakeholders raised is the potential for creating redundancy in developing a statewide solution that does not account for existing private sector, health IT solutions. Stakeholders expressed optimism about legislation enacted in June 2016 to create a state health

IT officer, which will move health IT oversight from the Department of Social Services to the Lieutenant Governor.

Stakeholders in both interviews and focus groups conveyed an eagerness to improve overall quality of care through the SIM Initiative. Within the context of these quality of care issues, the state has identified two relevant SIM goals, noted in the SIM quality council charter: (1) to achieve top-quintile performance among all states for key measures of quality of care, and (2) to increase the proportion of providers meeting quality scorecard targets. To meet these goals, the state plan includes identifying a core measure set and developing a multi-payer provider scorecard. Stakeholders reported that the process of identifying a core measure set has been long and arduous, albeit productive. Development of a common scorecard had not yet begun as of the 2016 site visit.

Connecticut has two aims for improving population health: (1) to reduce statewide rates of diabetes, obesity, and tobacco use; and (2) to close the gap between the highest and lowest achieving populations for key quality measures that currently demonstrate health disparities. To achieve these goals, the state is developing a plan that centers around two population health enabling structures: Health Enhancement Communities and Prevention Service Centers. The state envisions the former as a model for improving the health of communities with the greatest health needs; the latter will offer communities a portfolio of evidence-based interventions.

Connecticut's SIM Initiative has many components that will be implemented by multiple work streams. Many stakeholders were optimistic about the state's SIM payment and delivery reform strategies, given that payers and the state are generally focused on moving forward in the same direction. Stakeholders noted that it is hard to determine how all the pieces fit together, and felt that achieving multi-payer alignment across multiple work streams will be a difficult task. One stakeholder indicated that if the SIM Initiative were to begin again, it would be preferable to focus on fewer initiatives. Others pointed out that stakeholders who have bought into the plan will need to remain committed, as the health care landscape changes at both local and national levels. In spite of these challenges, stakeholders were pleased with the level of progress in most areas, satisfied with the highly inclusive SIM stakeholder process, and generally optimistic about transitioning to the SIM implementation stage.

4.3 Delaware

Delaware's SIM plan is the culmination of a multi-stakeholder, collaborative, consensus-based process, and its implementation continues this approach. The Delaware Health Care Commission led creation of the SIM plan, and continues in the policy setting role for the SIM Initiative. A central component of the Delaware SIM Initiative is creation of infrastructure to support the collaborative process during implementation. The Delaware Center for Health Innovation (DCHI) was formed as a nonprofit corporation to house the partnership and continue

the regular and significant involvement of stakeholders in the implementation process. SIM governance in Delaware places DCHI in a central role, but continues to recognize the unique and necessary role state government plays in setting policy in SIM implementation.

According to the state, the SIM goal is to “improve on each dimension of the Triple Aim,²⁶ plus one: to improve the provider experience.” Additionally, Delaware hopes to become one of the five healthiest states, to be among the top 10 percent of states in health care quality and patient experience, and to bring the growth of health care costs in line with gross domestic product growth. To achieve this goal, Delaware is using the following seven major initiatives to transform the health care delivery system:

- multi-payer, outcomes-based payment models
- care coordination for high-risk adults and children
- practice transformation for improved care coordination
- integration of primary and behavioral health care
- patient engagement in their health
- Healthy Neighborhoods to improve population health
- workforce capacity to implement team-based care for the state’s entire population

Health IT and data infrastructure support for the SIM Initiative is coordinated through the Delaware Health Information Network and supported by a health IT roadmap. Specific SIM-related technology initiatives include electronic health record (EHR) incentive payments to hospitals and eligible providers, development of a Common Scorecard and an APCD, and anticipated development of a Population Health Scorecard. The Common Scorecard and APCD will both provide data to measure SIM progress.

Delaware contains three distinct geographic areas with differing populations, challenges, and health care resources. Interviewees widely described Delaware’s current health care system as fragmented, disconnected, and characterized by inefficient competition among health care organizations and payers. The state has seven different health systems, with little service area overlap. More than 75 percent of Delaware’s physicians work in small practices with five or fewer physicians. Data from the Office of the National Coordinator for Health Information Technology indicates that less than half of the physicians share electronic patient information, a situation that results in care fragmentation. However, there is strong support for the SIM Initiative across state government in Delaware, with additional emphasis recently placed on engaging the legislative branch. Stakeholder participation has been broad based and generally

²⁶ Berwick, D. M., Nolan, T. W., & Whittington, J. (2008). The triple aim: Care, health, and cost. *Health Affairs*, 27(3), 759–769. doi: 10.1377/hlthaff.27.3.759

positive, with a recognition that patient and consumer stakeholders will require additional efforts to successfully engage.

The statewide changes Delaware expects to occur through the SIM Initiative include reduction of health care expenditures and improvements in health care utilization, care coordination, quality of care, and population health. The following paragraphs provide additional details about each of these changes, along with the results anticipated because of them.

Three SIM models are being implemented to impact high health care expenditures: payment model reform, care coordination, and Healthy Neighborhoods. For health care expenditures, SIM success is expected to lead to greater value received for money spent and a bending of the cost curve (i.e., a slowing in the rate of spending increase). Delaware expects to create \$282 million in cost-of-care savings through 2018 and \$3.8 billion through 2024, with the majority of savings in the early years reinvested in the delivery system. Delaware is leading the payment system reform initiative with its Pay for Value model, with its Total Cost of Care model to be developed later in the process. The payment reform initiatives, which are being met with guarded optimism in the state, will likely require early successes to increase participation and adoption.

Issues with health care utilization that Delaware stakeholders identified center on cost-effectiveness of available services (particularly those that are resource intensive) and overutilization of ER services. Several of the models specifically address health care utilization—through payment models, practice transformation, integration of behavioral health and primary care, care coordination, consumer education, and the APCD. Delaware expects that implementation of the above initiatives will result in more appropriate utilization patterns, including reduced ER use, increased management of chronic disease within primary care practices, and more balanced use by individuals with behavioral and physical health needs.

Delaware SIM leaders' vision is that all Delawareans should receive convenient, effective, well-coordinated care throughout the health care system. They also believe that coordinated care is foundational to achieving the Triple Aim. The three critical elements to achieving care coordination are practice transformation support, care coordination funding, and outcome-based payments to providers. Specific care coordination goals include effective follow-up after acute events and hospitalizations, development of care plans, and integrated care for patients with behavioral needs. Success of the care coordination initiative will be measured through improvements in provider performance on the Common Scorecard measures. The Scorecard uses Healthcare Effectiveness Data and Information Set and National Quality Forum measures and includes a measure based on the risk adjusted total cost of care per patient. It includes four utilization measures directly related to effective follow-up of acute events, such as follow-up after discharge and readmission rates. The remaining measures focus on process and outcome measures that demonstrate the result of care coordination. The process and outcome

measures include medication adherence and management for chronic conditions, population-based and condition-related screenings, and well-child visits, among others.

For Delaware, quality of care initiatives constitute an important component of the state's three SIM models—care coordination, outcome-based payments, and Healthy Neighborhoods—and, therefore, are not separately discussed by Delaware SIM leadership. Payers are encouraged to qualify for care coordination funding, if they achieve reasonable performance standards for quality of care.

Population health goals for Delaware's SIM Initiative will be largely addressed through the Healthy Neighborhoods model, although the entire SIM Initiative is focused on achieving improvements in population health—with obesity, diabetes, and tobacco identified as specific priorities. By attributing all patients to a primary care provider and incentivizing those providers to address specific priorities as well as total cost, Delaware's payers are shifting incentives to support population health.

During this initial analysis period, Delaware has established vendor contracts to support practice transformation, engaged with payers to plan for payment model rollout, and set up councils for the first three Healthy Neighborhoods. The RTI team will monitor several aspects of the Delaware implementation the state expects to achieve during the coming year. These aspects include an increased leadership role for DCHI; continued education of, and engagement with, primary care practices around SIM strategies; sustained collaboration with payers as payment model roll-out continues; implementation of health IT tools to support the initiatives; and further work to inform and involve consumers.

4.4 Idaho

Idaho's SIM Initiative aims to improve health outcomes, improve quality and patient experience of care, and reduce health care costs by \$89 million by 2019. Through the SIM Initiative, the state is implementing its Statewide Healthcare Innovation Plan, which will transform Idaho's primary care system into one composed of patient-centered medical homes (PCMHs) operating within an organized medical/health neighborhood.

The SIM Initiative builds on Idaho's experience in implementing and improving PCMHs. It was developed as a public-private partnership among stakeholders with a long history of working together to address the challenges of improving health care delivery in Idaho, which is a very rural state with a shortage of both primary care and behavioral health providers. Recognizing stakeholders' preference to advance health reform through consensus, the Governor created the Idaho Healthcare Coalition to guide SIM implementation. The Idaho Healthcare Coalition, as established by Executive Order in early 2014, includes representation from both the public and private sectors and is co-chaired by a representative of each sector. The Idaho

Department of Health and Welfare (IDHW) manages the initiative. Stakeholders were pleased with this structure and most expressed a feeling of ownership of the effort. A few (e.g., commercial payers and oral health providers) felt that they came “late to the table” and, therefore, had less influence over the initial planning; but they were still supportive of the SIM goals.

The Idaho SIM Initiative is based on implementing, supporting, and sustaining the PCMH model. Its core is practice transformation—supporting efforts of primary care practices to become medical homes and also expanding on this model by creating virtual PCMHs. The IDHW has already secured a contractor who will provide training and TA to the first cohort of 55 practices seeking to become a PCMH or qualify for a higher level of PCMH recognition. More than 100 practices applied to join the first cohort. Selected practices represent the full gamut of practices that provide primary care in Idaho, including FQHCs and community mental health clinics. Idaho plans to support three cohorts of practices—enabling 165 practices to transform during Award Years 2-4. The three major ongoing PCMH supports are (1) creating seven local Regional Health Collaboratives (RCs) that will organize hospitals, specialists, and social services into medical/health neighborhoods linked to primary care; (2) ensuring PCMHs have the information they need to assess and improve performance through increased HIE connectivity and implementation of a statewide data analytics system; and (3) moving from FFS to VBPs that will incentivize performance and sustain transformation.

Idaho is also developing virtual PCMHs to address severe provider shortages in rural areas. To become a virtual PCMH, a practice that has met basic PCMH qualifications must embed one or more of three modules into its practice: telehealth, community health emergency medical services (CHEMS) personnel, or CHWs. Stakeholders felt that telehealth would be especially useful for improving access to behavioral health services through PCMHs, since the provider shortage is particularly acute in rural areas. Idaho envisions training CHEMS staff and CHWs to serve in a variety of functions that augment the PCMH, including conducting home visits and helping patients access community resources. While the telehealth expansion is in the exploratory stages, the training materials for CHEMS personnel and CHWs are being developed for training sessions to be held later in 2016. The specifics of these models, including how they will be integrated into the PCMH model and how they will be paid, are still unfolding.

Idaho is creating seven RCs to support PCMHs—one RC per Public Health District. The IDHW supports the RCs via sub-grants with the districts. The sub-grants fund three staff in each district: a SIM manager, a quality improvement/quality assurance specialist, and an administrative assistant. The RCs are tasked with organizing the local medical/health neighborhood, supporting primary care practices in their PCMH transformation, and creating formal referral and feedback protocols that will better link local medical and social services

providers. Each district has already established an Executive Leadership Group and convened a physician-led RC stakeholder advisory group to identify local priorities and plan the work.

Many stakeholders were excited about the RC model and were satisfied with the progress made to date. But they also identified some challenges to success, including insufficient representation from consumer representatives and a lack of data for informed planning. The Division of Public Health is working to fill the data gap with public health data, and additional data will come from the statewide data analytics system once it is in place. Other stakeholders expressed concern that it is not yet clear how the RCs' work will be sustained after the SIM Initiative. Various stakeholders described different possibilities, such as RCs becoming risk-bearing entities or securing funding from payers or hospitals. Stakeholders emphasized that, at this early stage, it was important that each RC have the flexibility to develop its own strategic plan, including plans for sustainability.

To support the goal of ensuring PCMHs have the information they need to assess and improve their patients' health, Idaho is devoting significant resources to increasing EHR utilization and expanding participation in the Idaho Health Data Exchange (IHDE), the state's HIE. Practices associated with large networks typically exchange data well with other providers in the network, but smaller practices still struggle to use data effectively. Although many providers have EHRs, they often are not using them for referrals and follow-ups. Further, most are not participating in the IHDE or have chosen to pay to view data about their patients but not add their own data. Providers reported that EHR vendors' charges for connecting the EHR to the IHDE were high, and that often the IHDE had little information beyond that already known to the practice (partially due to lack of provider participation and because some Idahoans obtain services from out of state).

To address some of these issues, IDHW is using its SIM award to pay the fees for connecting EHRs to the IHDE and provide TA in the connection process for participating practices. These practices also receive TA to incorporate routine use of the data into their workflows. In addition, the Medicaid program has established a PCMH payment model that factors in practices' ability to exchange data via the IHDE, and rewards practices that have higher levels of connectivity. Most stakeholders were optimistic that these changes would enable the IHDE to improve the value of its offerings (i.e., be able to provide more data to users) and ultimately, engage more providers and payers to participate in it. Others, however, were not optimistic that the benefits could be improved enough to justify the cost of joining.

Idaho is implementing payment reform to transition from FFS to VBPs to incentivize performance and sustain the transformation, although they have encountered some challenges in this area. The SIM team had originally envisioned that Medicaid and all commercial payers would support ongoing PCMH costs through per member per month (PMPM) payments (in addition to the payments practices receive for delivering services). Many praised the Medicaid

agency's leadership in this area. Effective February 2016, the agency modified its existing Primary Care Case Management program to incorporate those practices that had participated in the Health Home pilot and align the payment structure with that envisioned in the SIM Initiative.

Commercial payers, however, do not wish to adopt a similar payment model. They prefer to continue to expand their own VBP models, including total cost of care and other risk-sharing arrangements that tie payment to performance on quality metrics. Payers preferred these models because they included a comprehensive set of services, could be administered at the network level, enabled them to build on the arrangements they already had in place with providers, and allowed them to differentiate themselves in the market. In response, Idaho's SIM leadership has modified their payment reform goal to "shifting 80% of all payers' payments to alternatives of FFS arrangements instead of targeting 80% of the State's population to the PCMH model." Several stakeholders expressed concern about reaching even this new goal without the involvement of Medicare or self-funded employers.

Idaho stakeholders recognize that demonstrating effectiveness is critical to sustainability. The Idaho Healthcare Coalition developed, via consensus, an Initial Performance Measures Catalog. The Idaho Healthcare Coalition's Health IT and Clinical Quality Measures work groups have worked together for the past year to develop specifications for these measures. This effort has been challenging, as providers in Idaho use many different EHRs that each collect and store data differently. The work groups have found that they need to focus initial efforts on a smaller number of key measures. They also plan to revise and refine the measure set to better align with national metrics, and to drop others that are no longer relevant. The work groups' task is also hampered by lack of a comprehensive statewide system for collecting data and producing the measures. The IDHW has recently secured a contractor to work with the IHDE to develop such a system, but that work is just beginning.

State officials hope the SIM Initiative will lead to reductions in expenditures and utilization. One of the primary mechanisms aimed at this goal is improvement of care coordination in the PCMH model and VBPs that reimburse these activities. Through increased IHDE connectivity and the incorporation of data in workflows, primary care physicians should be better able to coordinate care with specialists and hospitals, including closed-loop referrals and hospital discharge follow-ups. Further, primary care physicians will be better able to emphasize preventive care, conduct screenings that will help identify treatment needs earlier, and identify patients due for certain services, such as diabetic foot exams. Care coordination activities are also expected to improve quality of care, and as mentioned previously, the state is developing the capability to measure quality through specific metrics.

The SIM Initiative also supports IDHW's efforts to implement Idaho's existing statewide health improvement plan. The 5-year statewide population health improvement plan, *Get Healthy Idaho: Measuring and Improving Population Health*, published in July 2015, focuses on

four health priorities: (1) access to health care, (2) diabetes, (3) tobacco, and (4) obesity. The plan, which began prior to the SIM Initiative, was developed as part of the Division of Public Health's accreditation process, and its areas of focus are based on a statewide health needs assessment. As the SIM Initiative required a population health improvement plan, the state decided to combine the work of Get Healthy Idaho with that of the SIM Initiative. The leading health indicators identified in Get Healthy Idaho provided the framework for the primary data used in the statewide needs assessment and aligned with the SIM Initiative's efforts to improve health care and outcomes and reduce costs. Further, both recognize that the lack of patient-centered care in the state is a common underlying issue that contributes to poor health outcomes.

Overall, Idaho is implementing its SIM Initiative as originally proposed. However, some challenges have emerged during implementation. Stakeholders most often mentioned payer engagement and the HIE/data analytics as the greatest challenges they face at the end of the first analysis year. However, almost all stakeholders expressed confidence in the strategies developed to address these challenges.

4.5 Iowa

Iowa's SIM Initiative is intended to facilitate community-based collaborations between payers, providers, and public health entities to address population health needs and create a more sustainable health care delivery and payment system. In Iowa, the SIM Initiative has three primary aims: (1) improve population health, with a focus on three areas—diabetes, obesity, and tobacco use—so as to reduce the demand for health care; (2) transform the health care system to provide higher quality care at lower cost and thereby reduce preventable events, including preventable hospital re-admissions and preventable ER visits; and (3) promote the sustainability of system change by expanding the use of value-based purchasing. The SIM Initiative was awarded to the Iowa Medicaid Enterprise in the Iowa Department of Human Services, which is working collaboratively with the Iowa Department of Public Health and the Iowa Healthcare Collaborative, a nonprofit organization focused on health care improvement. The University of Iowa's Public Policy Center is conducting a state-sponsored evaluation of Iowa's SIM Initiative.

To achieve its three primary aims, Iowa's SIM Initiative focuses on four distinct strategies: (1) population health improvement activities, (2) improving care coordination via Community Care Coalition (C3) initiatives and the Statewide Alert Notification (SWAN) system, (3) expanding value-based purchasing to align incentives across payers and providers, and (4) providing community-based performance improvement to support C3 efforts in the context of value-based purchasing.

Iowa will measure the success of its SIM Initiative in several ways. First, the state expects value-based purchasing to increase, as evidenced by 50 percent of Medicaid, Wellmark Blue Cross Blue Shield (Wellmark) of Iowa (the dominant plan in the commercial market), and

Medicare payments linked to value-based purchasing contracts by 2018. Expansion of value-based purchasing along with SIM's care coordination efforts are intended to reduce preventable hospital re-admissions and preventable ER visits—for each of which Iowa has set a goal of 20 percent reduction by 2018. Finally, SIM's population health improvement activities target three areas: diabetes (increasing the A1c test rate), obesity (decreasing obesity prevalence), and tobacco use (increasing tobacco quit attempt rates). However, the ultimate measure of SIM Initiative success from the state's perspective will be continued growth of the value-based purchasing model across Iowa's health care system after the SIM Initiative ends.

Stakeholders noted three key elements of the Iowa health care system that provide context for the state's SIM Initiative: (1) the small size of the population and its ongoing shift from rural to urban areas; (2) the high degree of concentration in the health care market, with only a few key health care system players across the state; and (3) related to this market concentration, the strong history of collaboration within the state. In addition, several stakeholders noted that providers in the state have a history of providing high-quality care at low cost, which they attributed, in part, to the state's relatively low Medicare reimbursement rates and a dominant private insurer that bases much of its reimbursement structure on Medicare.

The most significant contextual factor influencing SIM implementation, however, has been the April 2016 introduction of risk-based managed care for the entire Medicaid population. Iowa's initial SIM efforts involved introducing ACOs into the Medicaid program, thus creating an alignment in care delivery with the existing ACOs serving Medicare and Wellmark's commercial populations. Following announcement of the Governor's plan to implement Medicaid managed care, the state restructured its SIM Initiative to give Medicaid managed care organizations (MCOs) the lead in contracting with ACOs and other providers to care for the Medicaid population and to implement value-based purchasing within these contracts. The new MCOs are also expected to interact with C3s and use SWAN to support care coordination across providers and within communities.

Across the board, stakeholders reported that because the introduction of managed care adds another layer to the health care system, it increases the complexity of implementing changes under the SIM Initiative. During focus groups conducted in two different regions of the state, both Medicaid-participating providers and Medicaid beneficiaries expressed concerns about the shift to managed care. Providers focused on the complexity of dealing with three unique systems across the MCOs, having to report separate transportation vendors, different drug formularies, and different rules on prior authorization. Beneficiaries in the focus groups described confusion and barriers to care associated with preauthorization and out-of-network providers.

Iowa invested in a strong stakeholder engagement process related to the SIM Initiative—which includes statewide and local public forums, work groups to address specific topics,

committee meetings and forums to target specific populations and issues, newsletters and dedicated websites, and learning collaboratives, among other things. Stakeholders reported active engagement in the SIM Initiative, with an open and collaborative relationship between the public and private sectors and among payers, providers, and public health. But some described the information from the state as having “stopped” during the transition period to Medicaid managed care that took place between 2015 and 2016.

By introducing value-based purchasing, which defines quality and efficiency based on the Value Index Score used by Wellmark, into the Medicaid program, Iowa intends to align the incentives across providers for the majority of their patients—with the goal of providing a more consistent focus on quality and efficiency in care delivery that will, in turn, reduce inappropriate care and improve population health. But many stakeholders who perceived value-based purchasing as the key driver of the SIM Initiative’s long-term system change expressed concern that the slowing of value-based purchasing implementation will make it difficult to establish the momentum with value-based purchasing needed to sustain health system transformation beyond 2018. Implementation of value-based purchasing progressed at a slower pace than program staff originally envisioned due to the introduction of managed care. Planning for and implementing managed care by 2016 required Medicaid officials’ time and attention, and the SIM Initiative had to be reframed to incorporate MCOs. In addition, value-based purchasing could not progress until managed care was implemented, because MCO contracts with providers are the vehicle through which value-based purchasing will move forward.

Two SIM elements support care coordination. First, the C3s are community-based coalitions of health and social service stakeholders collaborating to promote care coordination by providing assessment and referrals to needed community and social services. The C3s are also meant to drive rapid-cycle improvement strategies in their community. In March 2016, the first group of C3s was funded, with three contracts for implementation (covering a total of 10 counties) and three contracts for development (also covering 10 counties). The declining rural population in Iowa poses a number of challenges for C3s in terms of having both the population base to be sustainable and the clinical and administrative workforce available to run the C3s. Stakeholders also raised another challenge for C3s—that, while SIM funding is temporarily available to support implementation, C3s are ultimately expected to prove their value in supporting the goals of value-based purchasing, so the MCOs will have an incentive to pay the C3s for the work they do. As of this writing, the delay in value-based purchasing implementation impedes the opportunity for C3s to demonstrate their value to the MCOs.

Iowa’s second care coordination component, SWAN, is a health IT system developed under the SIM Initiative that makes real-time alerts and information available to providers on patients’ hospital admissions, discharges, and transfers (ADT) data. Iowa Medicaid Enterprise began to roll out SWAN with an early focus on ACO-led provider systems in 2016. Although

state officials reported that the ease of SWAN implementation has varied depending on the technical capacity and commitment of the given health system, they still felt confident that progress is being made. Many stakeholders agreed there is value in the type of information SWAN provides, but felt more work has to be done for the data to be useful; for example, one SWAN recipient reported not using the notifications yet, because they did not include the information needed to attribute patients to one of multiple service sites. Some stakeholders described SWAN as duplicating other internal efforts within ACOs and MCOs.

A major goal of Iowa's SIM Initiative is to improve population health. By building on existing public health efforts in the state, the SIM Initiative is expected to establish the infrastructure for continual population health improvement. More specifically, the SIM Initiative involves development of statewide plans recommending evidence-based approaches and clinical indicators to improve health care quality. The C3s and local public health departments will implement these statewide plans. So far, Iowa has developed plans for tobacco use prevention, diabetes, health care-associated infections, medication safety, nutrition and physical activity, and obstetrics. A statewide public health improvement plan focused on care coordination is currently in progress.

The C3s and the SIM team are encouraging communities to align with the statewide plans as they update their Community Health Needs Assessment and Health Improvement Plans (CHNA&HIPs)—which consist of objectives and strategies to address community health needs identified through community-wide discussions with stakeholders led by local public health departments. In conjunction with that effort, public health improvement activities under the SIM Initiative include tracking the clinical indicators communities target through their CHNA&HIPs, as well as rapid-cycle improvement around population-health measures driven by C3s, which also align priorities with their communities' CHNA&HIPs.

Efforts to improve care coordination and information sharing through the SIM Initiative depend on a strong health IT infrastructure, but according to stakeholders, Iowa continues to struggle in this area. While many large provider groups in Iowa use the Epic electronic record system, independent providers (particularly specialists) seldom use Epic, mostly because of its cost. As a result, stakeholders frequently pointed to lack of interoperability as an obstacle to care coordination. To address barriers to electronic information sharing, Iowa created the Iowa Health Information Network, a voluntary system that shares electronic patient health information among authorized users. However, most respondents felt that this system had not lived up to its potential and had failed to attract enough provider interest to become self-sustaining.

Workforce development is not a significant component of Iowa's SIM Initiative; however, stakeholders broadly reported workforce issues as a challenge for the system change envisioned under the SIM Initiative, as the state struggles with a shortage of workers, including administrative staff, who are now in greater demand to support the new MCOs. To address gaps

in provider supply, the state has implemented several initiatives over the last decade, including a Direct Care Worker Task Force—which led to creation of a training curriculum for health care workers, a Medical Residency Training State Matching Grant Program, and a Health Workforce Program Analysis (which concluded that Iowa has great unmet need for primary care physicians and psychiatrists, as well as large geographic disparities in workforce capacity).

Stakeholders felt that, by spring 2016, Iowa’s SIM Initiative had made progress on many fronts and was benefitting from a fairly concentrated health care market and a history of collaboration within the health care system. Moreover, nearly all stakeholders agreed with the SIM goals—though they shared mixed opinions about how ambitious or achievable these goals were in a 3-year period, particularly given the state’s switch to Medicaid managed care. Stakeholders also approved of the state’s overall approach to health care system transformation using Community-Based Performance Improvement.

At the same time, Iowa’s SIM Initiative is operating in an environment where many changes have occurred since the initial design of their SIM Operational Plan; and at the time of the 2016 site visit it was still unknown how these changes would affect the project’s overarching purpose—to foster community-based collaboration between payers, providers, and public health entities to address population health needs and create a more sustainable health care delivery and payment system. More specifically, stakeholders reported ongoing uncertainties in the health care market related to lingering effects of the Great Recession and health coverage and delivery-system changes spurred by the Affordable Care Act (ACA), and—most significantly—uncertainty about the changes introduced with the shift to Medicaid managed care in the state. Some stakeholders said that uncertainties about the impact of all these changes had made them hesitant about investing fully in the SIM Initiative.

Iowa’s Medicaid MCOs are now the primary vehicle through which the state’s goals must be implemented for expansion of value-based purchasing in Medicaid and the development of community-based care coordination through C3s. Yet stakeholders shared a number of concerns about the introduction of managed care and what they perceived as its negative impact on SIM implementation—as noted above, these ranged from provider and beneficiary concerns about new managed care processes to the slowing of value-based purchasing implementation while MCOs became established in the Medicaid program.

An additional concern some stakeholders expressed was that the introduction of managed care changed the structure of collaboration around the SIM Initiative, placing an additional entity—the MCOs—between providers and the state agencies. With Medicaid MCOs operating for less than 2 months at the time of the 2016 site visit, it is far too early to assess the full effects of Medicaid managed care for Iowa’s SIM Initiative. The RTI team will monitor this aspect of Iowa’s SIM Initiative closely, in addition to studying ongoing SIM implementation generally and the state’s progress towards reaching the SIM Initiative’s goals.

4.6 Michigan

Michigan’s SIM Initiative builds on the 2014 *Blueprint for Health* vision for “healthy, productive individuals, living in communities that support health and wellness, with ready access to [an] affordable, patient-centered and community-based system of care.”²⁷ The state’s SIM Initiative aims to improve patient care (including quality and patient experience), reduce per capita cost of care, and improve population health. To achieve these aims, Michigan plans to implement three major initiatives—patient-centered medical homes (PCMHs), Accountable Systems of Care (ASCs), and Community Health Innovation Regions (CHIRs)—which are described as follows:

- ***Patient-Centered Medical Homes.*** PCMH is a care delivery model whereby a patient’s treatment is coordinated by their primary care physician, is the foundational pillar of Michigan’s SIM strategy. The state plans to build on the existing strong PCMH infrastructure and work in targeted regions to increase PCMH recognition standards and the extent of adoption.
- ***Accountable Systems of Care.*** ASCs are Michigan’s variant of ACOs. In ASCs, health plans and providers will earn bonuses if they achieve spending growth targets while meeting certain quality metrics. Managed care plans will be required to contract with ASCs under the SIM model. All ASCs will include PCMH practices in their provider networks.
- ***Community Health Innovation Regions.*** CHIRs are an especially innovative feature of Michigan’s SIM Initiative designed to address social determinants of health to improve overall population health. CHIRs will work with ASCs and health care providers to facilitate quality improvement and lower spending by linking clinical resources with community-based social services.

The state will support these three initiatives with: (1) Alternative Payment Methods (APMs) for ASCs, which all interviewees expected to be based on a shared risk/shared savings model, but which are not yet fully worked out; (2) quality performance metrics that will be used to measure progress and will be linked to APMs but are still being developed; and (3) refinements to existing health IT processes to facilitate performance metric collection and reporting, care coordination, and population health improvement.

The analysis period for this report is February 2015 through June 2016, and the site visit took place in May 2016. At the time of the site visit, Michigan’s implementation progress had been delayed, and key components of the demonstration were slated to begin later in the year. As a result, the findings described here are limited. To make the process more manageable, Michigan plans to implement the SIM Initiative in five regions: Jackson County, Genesee

²⁷ State of Michigan. (2014, January 24). *Reinventing Michigan’s health care system: Blueprint for health innovation*. Retrieved September 23, 2016, from http://www.michigan.gov/documents/mdch/Michigan_Blueprint_APPENDICES_REMOVED_454499_7.pdf.

County, Muskegon County, Washtenaw and Livingston Counties, and Northern Michigan (a largely rural area comprising 25 counties). These five areas were selected from 14 that had applied for consideration, because they offered state officials an interesting mix of circumstances under which to test SIM Initiative models. Some regions have sophisticated health and community systems that were ready to move forward, while others were going to need more development. Within these five regions, the state plans to focus on three priority populations: (1) frequent ER utilizers; (2) individuals with multiple chronic conditions; and (3) mothers and babies. The state also decided to focus SIM activities on Medicaid beneficiaries and managed care plans, as opposed to involving other payers directly.

Michigan's SIM Initiative builds on years of health system improvement efforts in the state, although the need for further change is widely acknowledged. Stakeholders saw the medical home model, promoted under the Michigan Primary Care Transformation (MiPCT) Demonstration project, as an important building block for the SIM Initiative. MiPCT is a multi-payer demonstration to test payment reform models and expand PCMH capacity throughout the state.

Several other initiatives in Michigan are also viewed as part of SIM's foundation:

- The Michigan Children's Health Access Program is a pediatric medical home demonstration;
- Blue Cross Blue Shield's Physician Group Incentive Program is a medical home transformation program that has been operating in the state for over a decade; and
- Michigan's HIE was established in 2010 and plays a foundational role in the health IT-related aspects of the SIM Initiative.

These initiatives are described in greater detail in *Appendix F*. Additionally, the Flint water crisis and the work it requires is a contextual factor that has redirected the time and energy of many state staff who would otherwise have been involved in the SIM Initiative.

Both state officials and other stakeholders reported that building on extant work and infrastructure has been critical in facilitating the involvement of major payers and providers and moving to an anticipated successful SIM launch. Multiple interviewees described the transition from MiPCT to the SIM Initiative and the use of existing community networks to create CHIRs and ASCs as wise decisions that will enable smooth implementation. For example, some of the stakeholder engagement strategies were adopted from the MiPCT initiative—one state official noted that the SIM team had “adopted” MiPCT work groups and committees for the SIM Initiative. Other interviewees pointed out that the MiPCT initiative had strong stakeholder support throughout the state and provided a strong basis for SIM development. These factors helped the state easily transition from MiPCT to SIM activities.

Beginning with the Model Design, Michigan has included a wide spectrum of stakeholders in its planning and decision-making processes. Among these was Blue Cross Blue Shield of Michigan, the largest commercial insurer in the state and one that serves individuals and families covered under Medicaid and the Healthy Michigan Plan through Blue Cross Complete. Michigan also used its Medicaid MCO contracting process to encourage plans to suggest methods that could feed into SIM's VBP approaches.

Another key stakeholder group is major health systems, including Physician Organizations and Physician Hospital Organizations, the types of groups likely to form the ASCs. Representatives of these systems have been involved throughout the development and implementation of the SIM Initiative through formal participation in the advisory committee and work groups. Jackson Health Network leadership helped the state develop the ASC and CHIR concepts during the SIM application period and also traveled to Washington, DC, to help present the Model Test cooperative agreement request to CMS. This level of inclusion did not extend to all, or even most, stakeholders, however; and numerous groups felt as if their participation was limited in scope.

The largest challenge to stakeholder engagement to date occurred during the fall 2015 MCO re-bid process when the state imposed a period of "radio silence" on SIM communication so that the managed care contracting process would not be influenced by SIM planning efforts. This period lasted approximately 6 months. Many stakeholders wondered what had happened to the SIM Initiative after many months of active participation followed by no communication, and felt this period contributed to frustration and a loss of momentum. State officials were aware of these frustrations and acknowledged the problems the protracted planning process caused. Despite delays, all stakeholders appeared organizationally ready to participate at the time of the 2016 site visit.

Due to delays, the state had not yet implemented any of the major components of its SIM model at the time of the visit, so most of the findings reported here are related to Michigan's plans looking forward. State officials and other stakeholders almost uniformly agreed that the CHIRs are the component of SIM with the greatest potential to have a significant effect on population health, and that health IT use and improvement will be critical to CHIRs' success. Michiganders saw CHIRs as especially promising, because they build upon established community and regional organizations and networks, while adding funding and a framework for new efforts to improve community health and access to social services. However, stakeholders widely agreed that there was greater certainty around the success of expanding PCMH due to the large base of PCMHs already created by MiPCT (among other similar initiatives) and the willingness of payers to fund medical home development and activities.

As of the time of the 2016 site visit, the most significant change in the SIM Initiative aimed directly at controlling health care spending is the movement to VBP for ASCs. Payment

incentives will give ASCs the opportunity to participate in shared-savings or shared-risk payment models. Interviewees hoped this could optimize health care utilization by incentivizing primary care delivery and reducing unnecessary emergency care. The SIM Initiative's focus on the PCMH model of care supports this shift and encourages patient education.

However, given the relatively short implementation and evaluation period, state officials acknowledged that bending the cost curve would be difficult, and they might not see significant reductions in expenditures during the SIM Initiative. As of the 2016 site visit, the SIM model was not yet operational; but the state planned to officially kick off major SIM Initiative activities in each of the five participating regions by late 2016.

4.7 New York

At the heart of New York's SIM Initiative is a state-designed PCMH model, called the Advanced Primary Care (APC) model. In the first year of New York's 4-year, \$99.9 million SIM cooperative agreement, state officials and a wide range of external stakeholders spent the bulk of their time fleshing out and refining the APC model. At the time of the 2016 site visit, New York hoped to launch the APC model beginning in fall 2016 by having (1) contracted organizations provide SIM-funded TA to help practices meet APC standards, and (2) payers provide new payments to primary care practices that adopt the model. To encourage payer participation, New York is providing modest financial incentives through the state's annual approval process for health insurance premium rates, by allowing payers to include APC payments in the numerator of their Medical Loss Ratios. New York is not using SIM funds to make APC payments to practices.

Although the APC model is at the center of New York's SIM effort, the SIM Initiative includes other important components, chief among them: (1) furnishing APC practices with a scorecard summarizing their performance across different payers on a common set of quality measures, (2) increasing the quantity and quality of the state's health care workforce through various efforts, (3) advocating for VBID changes to state employee health plans, and (4) improving population health by funding a few pilot communities to convene stakeholders to develop interventions aimed at addressing a common health improvement goal.

For this last component, New York had originally envisioned funding public health consultants to work one-on-one with APC practices to encourage them to refer patients to social services agencies in the community. In spring 2016, however, the state decided instead to award SIM funds to local organizations (such as local health departments) in a few targeted geographic areas, to bring together key community stakeholders to foster population health reform. This change was reportedly made in response to a concern that individual public health consultants would not be sufficient to meaningfully influence population health, and there was a need to

broaden the scope of the population health activity by involving more individuals and organizations to create multisector collaboration.

Meanwhile, Year 1 health IT activities focused largely on gathering stakeholder input on data sharing and connectivity issues associated with the Statewide Health Information Network for New York (SHIN-NY) and the New York All-Payer Database (APD). The state hoped to increase providers' and payers' use of SHIN-NY and the APD, so that quality measures distributed as part of the APC effort could eventually be generated using these data sources. SHIN-NY regulations were promulgated in fall 2015, and an APD regulation was under development at the time of the 2016 site visit.

New York has a vast, diverse, and complicated health care system, in which certain features may help or hinder the state's ability to implement its various SIM activities. For example, on a positive note, interviewees mentioned competition among New York's many commercial payers as an asset. According to interviewees, having multiple payers in the market has helped drive health care innovation in the state, including several efforts aimed at transforming primary care that predated the SIM Initiative. New York has also developed valuable experience launching and running multi-payer medical home initiatives, according to interviewees. One state official remarked that they "shamelessly stole" elements from these other earlier initiatives when they designed the APC model. These and other pre-existing efforts may make it easier for New York to convince payers and practices alike to participate in SIM's APC effort.

At the same time, having multiple payers could pose a barrier to implementing the APC model, stakeholders explained, because to influence a preponderance of the care provided in New York, the state must convince more payers to join than they would have needed to had there been fewer larger payers in the state. Another barrier to APC implementation is the fact that some private insurers have already implemented primary care payment models that they think incorporate the basic elements of the APC model (or even go beyond the APC requirements), yet these payment models are not being considered APC payments by the state since they predated the SIM Initiative. Another potential barrier several interviewees noted is that New York has a "very inpatient- and hospital-focused delivery system," which may prove difficult to move to a system more focused on ambulatory care, as envisioned under the APC model.

Another challenge has been the 2015 closure of Health Republic Insurance of New York, a consumer operated and oriented plan developed to compete in New York's health insurance marketplace. The state had approved Health Republic's low premium rates but then had to shut the plan down due to financial losses. Some critics felt the state should not have approved premiums that were so low that it put Health Republic out of business. Because of this action, some critics believed the state should be relieved of its authority to approve health insurance premium rates altogether. Others felt that Health Republic's closure was in large part due to deep

federal cuts to a risk corridor program for ACA consumer operated and oriented plans, which reduced an expected infusion of funds from \$200 million to \$19 million.²⁸ The suggestion that the state had something to do with Health Republic’s closure was viewed by several interviewees as casting a shadow on SIM progress—both because it distracted officials from focusing on the SIM Initiative, and because the rate review process is an important policy lever New York is using to encourage payers to make new APC payments to practices.

Interviewees identified a proliferation of other health care payment and delivery system reform initiatives in the state as another obstacle to SIM implementation. They worried that these other efforts may cause confusion or “transformation fatigue” among health care providers, which may cause providers to decide not to participate in the APC model. Interviewees shared a general sense that there may already be too many efforts that have asked providers to take on additional activities beyond their day-to-day duties (e.g., taking time out of their busy schedules to learn how to use EHRs systems, and to modify practice workflows to accommodate such systems). Interviewees feared that providers may be unwilling to take on yet another such effort.

Concurrent with the SIM Initiative (which will focus on smaller practices that primarily serve privately insured patients), New York’s Medicaid Delivery System Reform Incentive Payment (DSRIP) program aims to help primary care practices that serve safety-net populations adopt the National Committee for Quality Assurance PCMH or SIM APC models of care, among other goals.²⁹ Given the similarity among these initiatives, some interviewees worried that

²⁸ Waldholz, M. (2016, April 17). The short and chaotic life of an Obamacare darling. *Crain’s New York Business*. Retrieved September 14, 2016, from http://www.craigslist.com/article/20160417/HEALTH_CARE/160419890/the-short-and-chaotic-life-of-an-obamacare-darling.

²⁹ New York’s \$8.25 billion DSRIP program was approved by CMS in 2014 as a Medicaid waiver amendment. Its goal is to reduce avoidable hospital use by 25 percent by transforming the state’s health care system. DSRIP requires Medicaid providers and community-based organizations to join Performing Provider Systems (PPSs) led by safety-net providers (usually hospitals) in exchange for receiving new DSRIP funding. DSRIP funds are disbursed to the safety net provider organizations leading each PPS, which in turn distribute funds to participating PPS organizations. PPS participating organizations work together to implement five to 11 clinical projects (chosen from a menu of 44 pre-specified projects), such as by building care management and population health management infrastructure. PPSs must complete certain milestones (e.g., by the end of the third implementation year, all PPS primary care providers must become certified PCMHs) and must also report to the state on a set of process measures and must meet a series of performance measure targets (e.g., reducing potentially avoidable ER visits). The state reports quarterly to CMS; if milestones are not met, CMS will reduce the state’s total DSRIP funding. By the end of New York’s 5-year DSRIP waiver, 80 percent of Medicaid managed care plan payments to providers are required to use value-based methodologies. As part of DSRIP, New York has also committed to building a Medicaid Analytics Performance Portal, which will act as a data warehouse, contain performance dashboards, and serve as an electronic care planning tool. New York has also committed to sharing Medicaid claims data with PPSs, and requires PPS providers to be connected to a regional health information organization. Bachrach, D., Bernstein, B., Augenstein, J., Lipson, M., & Ellis, R. (2016, April 21). Implementing New York’s DSRIP Program: Implications for Medicaid payment and delivery system reform. The Commonwealth Fund. Retrieved from <http://www.commonwealthfund.org/publications/fund-reports/2016/apr/new-york-dsrp-medicaid>.

primary care practices would be confused about which program—DSRIP, APC, or some other competing program—they should join.

Finally, the makeup of the state’s primary care provider workforce may present a barrier to adoption of the APC model. Like other states, interviewees frequently characterized New York as having an aging physician workforce, which often works in small, under-resourced practices staffed by only one or two providers. These physicians were described by interviewees as being financially less able to invest in new staff (e.g., care coordinators) or new technologies (e.g., updated EHRs), and therefore less interested in adopting the APC model.³⁰

The focus groups, which were conducted in Albany, explored experiences of practicing primary care clinicians who were not in PCMHs to understand their views of the current health care landscape. Most of the focus group clinicians worked in small, under-resourced practices and generally felt frustrated and overwhelmed by the numerous public and private payer programs and state and federal requirements foisted upon them. Many of the clinicians also reported they had not adopted the PCMH model of care, because they had either not heard of it or viewed it as too expensive and time-consuming to take on. Given this latter complaint, the generosity of payments that payers ultimately offer to providers to adopt the APC model may have a major impact on whether providers, like the ones in the focus groups, feel able to adopt this new delivery model.

Since the beginning of Award Year 2 of the SIM Initiative, New York has met many logistical milestones, and both state and non-state stakeholders generally had a favorable view of the process through which these goals were achieved. Among New York’s many accomplishments in Year 1 were (1) forming and staffing a new office within the New York State Department of Health to lead the SIM Initiative; (2) contracting with various vendors to assist with SIM implementation; and (3) quickly forming, repurposing, or sharing work groups and using them to generate active and sustained engagement from both external stakeholders and a wide range of state staff representing different agencies. State staff leading the SIM effort earned kudos from most interviewees for being receptive to feedback and balancing diverse perspectives—though consumer advocates felt their views had been under-represented in the design of the APC model, particularly as it pertains to consumer engagement.

Next steps in implementation of New York’s SIM Initiative. After what was generally viewed by most stakeholders as a successful period planning the SIM Initiative, New York is now shifting from refining to implementing the APC model. This will be the core activity for the state in Year 2 to advance its SIM effort.

³⁰ Researchers have previously found that small practices are less likely to obtain PCMH certification than larger practices. Raffoul, M., Petterson, S., Moore, M., Bazemore, A., & Peterson, L. (2015, April 1). Smaller practices are less likely to report PCMH certification. *American Family Physician*, 91(7), 440.

There was near universal agreement among interviewees that moving from agreement on design of the APC care delivery model to voluntary adoption of an APC payment model by payers will be a significant challenge. New York, as noted, has backed away from its original plan of statewide implementation, and is instead implementing the APC model through a phased roll-out, starting in regions with a sufficient number of receptive payers and providers. In addition, New York is giving payers considerable flexibility in deciding how to structure APC fees, how generous to make the fees, and when to pay them to participating practices. As of the 2016 site visit, however, no payer had formally committed to offer new payments to practices that adopt the APC model. As one stakeholder put it, “the commercial payers have been as non-committal as they can be.”

From the perspective of one state official, payers’ reluctance seems to stem from their “need to be convinced that [making APC payments is] really going to improve care, and has a shot of really doing something on affordability”; yet, because it is a competitive environment, these payers also “want to know it’s not going to hurt them, relative to their competitors,” if they start making APC payments. Put another way, payers are fearful of free-riders taking advantage of them: no payer wants to get into a situation where it is the only payer making payments to a practice to develop APC infrastructure, while other payers’ patients benefit from these practice enhancements.

Providers voiced concern that even if payers agree to make new payments to APC practices, the payers may choose not to make payments until providers reach an advanced level of APC implementation. This timeline was seen by some interviewees as problematic, because providers would have to come up with upfront funds for costs like hiring a care coordinator. The lack of upfront payment from payers in the early years of a practice’s APC implementation could limit provider participation in the APC model, especially among the small practices that are the focus of the state’s SIM Initiative. As one observer put it, “I don’t think we can sell the APC model with no payments until you reach Gate 3.”

Based on the 2016 round of interviews, it appears that payers and providers in New York are each waiting for the other to embrace the APC model, before they agree to support it. According to some interviewees, payers do not want to start paying practices the new APC payments, until practices have partially or fully adopted the APC model, while practices do not want to start adopting the APC model unless payers are willing to pay them upfront for their time and expenses.

4.8 Ohio

The Ohio SIM Initiative was launched in 2014 with the goal of moving the state's health care system toward a VBP model. Ohio aims to achieve this goal through two key strategies: PCMHs and episode of care (EOC) payment. Using these two initiatives, Ohio's goal is to cover 50 percent to 60 percent of the state's medical spending and 80 percent to 90 percent of the state's population over the next 5 years. In addition, Ohio is engaged in health IT, workforce development, and population health initiatives.

Unlike some other states, Ohio's insurance market is highly competitive, with no health insurer covering more than 20 percent of the market. Stakeholders described the Ohio health care system as dominated by large health systems in major markets and historically driven by FFS-based care. Although the state has urban centers, many interviewees stressed the importance of the needs of the rural population in the Appalachian region.

Ohio has an extensive history of health reform initiatives over the last several years. In 2011, the Governor created the Office of Health Transformation (OHT) in the Governor's Office to (1) modernize Medicaid, (2) streamline health and human services, and (3) improve Ohio's overall health system performance. Ohio is participating in many federally funded, health care innovation activities. Stakeholders identified implementation of CMS' CPC+ initiative as having an important potential impact on SIM PCMH implementation.

OHT leads Ohio's SIM Initiative, provides oversight on behalf of the Governor, and directs and coordinates line agency efforts with the private sector and stakeholders. OHT has engaged diverse stakeholders in the design and implementation of the SIM Initiative in many ways, including establishing numerous external workgroups, convening innumerable meetings, holding focus groups with providers, and conducting a survey of primary care providers. Given the Governor's commitment to nonregulatory approaches to health transformation for non-Medicaid providers and insurers, voluntary buy-in by these stakeholders is key to SIM implementation beyond Medicaid. Participating stakeholders generally believed the state leadership valued their input, although some consumer advocates contended their perspectives did not carry the same weight as those of providers or payers.

PCMHs and EOCs are Ohio's two main delivery system and payment reforms under SIM Initiative. Although clear and intended overlaps exist between the two initiatives, EOCs mainly target specialists, and PCMHs mainly target primary care physicians.

As in other parts of the country, Ohio is attempting to reinvent primary care and make it central to the health care delivery system by promoting PCMHs. Ohio has worked to make its PCMH model flexible enough to meet the needs of different types of providers and geographic areas, as well as encourage participation by as many practices and patients as possible. All

participating PCMH practices will have access to PMPM payments tied to meeting activity, efficiency, and clinical quality measurement requirements. In addition, many practices will have access to shared savings payments for achieving total-cost-of-care savings compared to either their own previous performance and/or that of their peers. Some practices also may be eligible for a one-time practice transformation support payment to help them begin to transition to a PCMH.

In 2015, OHT and the Ohio Department of Medicaid decided to accelerate the implementation timeframe originally proposed for the PCMH Model Test implementation, moving to a statewide rollout. In June 2016, the Ohio Department of Medicaid proposed a new regulation setting the Medicaid policy and payment infrastructure for PCMHs. All Medicaid managed care plans will be required to offer PCMH payments to participating practices. Ohio also has made recent changes to its planned PCMH model requirements to align with the CPC+ initiative.

Ohio's EOC-based payment model seeks to encourage high-quality, patient-centered, and cost-effective care by holding a single provider or entity accountable for care across all services related to a given episode. Providers are subject to positive and negative payment incentives, depending on their costs and quality metrics. Medicaid requires its managed care plans to implement the EOC payment system in the manner specified by the state, and commercial insurers have promised to implement EOCs roughly following the Medicaid model. Since receiving the SIM award, Ohio has reconsidered its fairly measured pace of developing episodes, and now plans to develop and implement 50 EOCs over the next 2 years. Ohio's EOC-based payment model was launched in 2014 with the design of five, wave 1 episodes: asthma (acute exacerbation), perinatal, chronic obstructive pulmonary disease exacerbation, percutaneous coronary intervention (i.e., angioplasty), and joint replacement. The state also has developed seven wave 2 episodes: upper respiratory infections, urinary tract infection, cholecystectomy, appendectomy, upper gastrointestinal endoscopy, colonoscopy, and gastrointestinal hemorrhage.

Ohio's multi-payer coalition created an EOC-based payment charter to determine levels of payer alignment across three main elements:

- ***Accountability.*** Within each EOC, a principal, accountable provider is identified as the provider best positioned to assume accountability for the episode.
- ***Retrospective payment model.*** Incentive payments to reward cost-efficient, high-quality care are calculated retrospectively. That is, payment incentives are made to reward or disincentivize past performance by the provider.
- ***Positive and negative financial incentives.*** Providers that have significantly lower than average costs and meet the quality metrics will receive positive incentive payments; providers who have significantly higher than average costs will be subject to payment reductions.

As of the June 2016 site visit, OHT staff had not focused on health IT and workforce development as part of their SIM award. SIM's population health strategy focuses on alignment among the existing population health statewide and local initiatives, as well as between these initiatives and the PCMH and EOC health care transformation strategies. Some of the quality measures for PCMHs and EOCs align with the population health focus areas. The state also wants to coordinate and align the many health-planning activities that exist in Ohio at the state and local levels.

State officials felt little need for the TA offered by CMS, in part because they found the available assistance too general. Although stakeholders generally noted a positive working relationship with CMMI, some interviewees expressed frustration with other components of CMS involved with approving state plan amendments and with the lack of coordination among the different CMS components.

In this first report period, the state had not implemented its SIM Initiative; there are no data to evaluate any changes in outcomes. Stakeholders, including state officials, were very focused on implementing the SIM strategies and were not concentrating on exactly what the effects of the changes were likely to be. In general, stakeholders expected the SIM Initiative to be a positive help in controlling the rate of growth in health care expenditures, reducing unnecessary utilization of expensive services, and improving quality of care and health outcomes. However, certain stakeholders, including some who are actively involved in the SIM Initiative, voiced skepticism about whether the state would succeed in its efforts to transform the health care system. However, even the skeptics said they were eager to see the changes the SIM Initiative will make.

4.9 Rhode Island

The vision for the Rhode Island SIM Initiative is to improve population health and advance statewide delivery system transformation. Rhode Island is operationalizing this vision by making significant investments in training its health care workforce to deliver more integrated care and expanding the state's capacity to use health IT to enhance care quality.

The state's delivery system and workforce investments include the following: (1) bolstering the adoption of VBP models by expanding the state's current PCMH model to children, (2) delivering practice transformation support to physicians to enhance the integration of behavioral health and primary care, and (3) financing the development of community health teams to deliver more coordinated care to high-risk patients.

To strengthen the state's health IT infrastructure, the state proposes to increase the utility of the state's APCD, complete development of a statewide common provider directory, and create a unified quality measurement and reporting system to improve the state's data analytic

capacity. Next year, the state also intends to develop patient engagement tools to help consumers better understand and participate in their own health care. At the conclusion of the SIM award, the Rhode Island SIM Initiative hopes to achieve an increased level of alignment and coordination across existing health care delivery reform initiatives occurring throughout the state.

Rhode Island has a long history of promoting health care delivery transformation. In 2008, the state implemented one of the first multi-payer PCMH initiatives in the country. A few years later, the former Governor created the Rhode Island Health Care Reform Commission, which recommended strengthening the state's primary care infrastructure and experimenting with new payment models to boost quality and reduce costs. Recent policymaking activities have continued to foster delivery system transformation across the state. In 2015, the current Governor signed an executive order that created a Working Group to Reinvent Medicaid, which outlined an approach to improve the value and quality of health care delivered in the Medicaid program. That same year, the Governor assembled the Working Group for Healthcare Innovation, which generated recommendations to spur health care transformation across the private and public sectors. The Rhode Island SIM Initiative borrows from these complementary efforts to continue on the path of statewide payment and delivery reform.

Rhode Island received a \$20 million award to implement its SIM Initiative over a 4-year period. SIM activities officially started in February 2015; however the state received a 5-month, no-cost extension, delaying release of the initial Operational Plan until May 31, 2016. At the time of the 2016 site visit, Rhode Island had just hired a new project director to lead the SIM Initiative. Prior to the director's arrival, the state did not have full-time staff dedicated to overseeing the project, which resulted in confusion about SIM's intent and purpose. During the 2016 site visit, the stakeholders with which the RTI team consulted universally acknowledged the important role the new SIM project director played in achieving consensus among Steering Committee members and creating an overarching vision for the Rhode Island SIM Initiative. Many state officials and committee members highlighted the director's involvement as particularly noteworthy, given that the original budget request for implementation was \$60 million, and the state was awarded \$20 million. Almost all state officials and external stakeholders involved in the SIM decision-making process commented on how effective the project director was at managing this prioritization process and creating a solid framework for implementation.

Most interviewees described the stakeholder engagement process as inclusive and open, with broad representation from critical partners. However, a handful of interviewees expressed a desire to have a stronger patient voice represented on the SIM Steering Committee in the coming years.

Additionally, most stakeholders were supportive of the SIM vision and investments—describing SIM activities as appropriate and timely, given the policy direction in which the state was heading at the time of the SIM award. A few interviewees expressed concerns about the SIM project team’s plans to transform behavioral health care, indicating that the state needed to do some additional work formulating a more unified vision for behavioral health integration across the state. According to some provider representatives, health care providers are implementing varying models of integration, which warrants provider concern that SIM involvement could result in new and conflicting practice transformation requirements. Some respondents also noted reservations about the sustainability of some SIM investments, particularly the training and implementation of new community health teams in underserved areas. As health care providers are expected to further reduce costs and improve efficiency, financing new clinical team members could become more challenging in the years to come.

4.10 Tennessee

Tennessee’s SIM Initiative was launched in 2015 to reform health care payment and delivery in the state and shift to a health system grounded in VBP. Health system transformation under the SIM Initiative comprises three overarching strategies:

- ***Episodes of care.*** The state will implement 75 EOCs, tied to acute health care events (such as a surgical procedure), in 11 waves by 2019. An EOC will hold one key provider accountable for the overall cost and quality of care provided by all relevant providers around a given health event. The first wave, which included three episodes, went into effect in May 2014.
- ***Primary care transformation.*** Tennessee will develop initiatives that promote the primary care provider’s role in managing chronic diseases and delivering preventive services. This strategy includes three components: an aligned, multi-payer PCMH model; Health Links to serve as health homes for high-risk TennCare (the state’s Medicaid program) members with acute behavioral health needs; and a provider-facing care coordination tool (CCT) that includes ADT data for attributed providers. Twenty-five PCMH practices are scheduled to launch in January 2017, which will build to a statewide, aligned, commercial and Medicaid PCMH program. Health Links will launch in fourth quarter 2016.
- ***Long-term services and supports.*** Tennessee will build upon existing initiatives focused on improving quality and shifting to VBP for nursing facility services and home and community-based services for seniors and adults with physical disabilities and for individuals with intellectual and developmental disabilities. Tennessee is several cycles into a program to improve quality reporting for nursing facilities that includes meaningful quality metrics. Going forward, the state aims to standardize quality reporting across nursing facilities and tie prospective facility payments to standard quality metrics. In addition, the state will shift away from a per diem reimbursement structure for enhanced respiratory care services to VBPs that incentivize liberating patients from a ventilator. Tennessee also is developing the

long-term services and supports (LTSS) workforce by developing a registry of direct care workers along with a curriculum that aligns with direct care worker core competencies.

The Office of Strategic Planning and Innovation within the Tennessee Health Care Financing Administration (HCFA) provides day-to-day leadership and coordination for the SIM award. Responsibility for implementation of specific SIM Initiatives is assigned to the appropriate units of state government, with all areas of HCFA deeply involved. Tennessee supplements state staff with consultants. The state also contracts with the Tennessee Medical Association to conduct outreach to physicians regarding EOCs and primary care transformation. Tennessee contracts with the Tennessee Chapter of the American Academy of Pediatrics to assist physician offices to conduct quality improvement projects. The state has retained five schools of public health to develop regional population health improvement plans that form the basis of a statewide plan. Finally, the Medicaid MCOs and public employee health plans perform the data analyses to support implementation of approved EOCs and conduct provider outreach. State officials report that the total of these resources is sufficient to implement and test the SIM Initiative.

Tennessee's SIM Initiative affects multiple groups of stakeholders statewide; the state has devised a diverse, intense, and multifaceted strategy to obtain their input. Tennessee reported having conducted 76 separate stakeholder meetings in first quarter 2016 alone. The strategy includes use of technical advisory groups comprising payers, providers, and state staff; implementation and operations meetings with MCOs; and regular meetings with provider associations, community forums, presentations to external groups, monthly calls with providers, and implementation work groups with LTSS providers. State officials value their positive and collaborative relationship with other payers and with providers in the state.

Interviewees largely agreed the state did a good job of soliciting diverse stakeholder feedback and being inclusive of multiple stakeholder perspectives. Many interviewees expressed their appreciation for the state's leadership and accessibility and for the overall vision of the TennCare team. Several stakeholders also mentioned arranging personal meetings or calls with the state implementation team. However, consumer advocates felt that, although the state did a good job engaging with provider and payer stakeholders, opportunities for consumer engagement were weak.

Tennessee is in the early stages of health care system transformation under the SIM Initiative. Nevertheless, based on information gathered from stakeholders during the 2016 site visit, the state is making progress in implementing primary care transformation, EOCs, and LTSS payment reform. EOCs have rolled out on schedule, with five of 11 waves developed, and the first two implemented. Health Link is scheduled to be implemented statewide in fourth quarter 2016, and PCMH implementation will begin in January 2017. LTSS initiatives and

development of the CCT are also proceeding on schedule. The statewide population health improvement plan is undergoing finalization.

While Tennessee is still early in the process, state officials report initial indications from the state's data on the first performance period for the first wave of episodes that average quality is improving, and average costs are decreasing. State officials are also very satisfied with implementation to date of the CCT. Implementation of this state-hosted electronic CCT is proceeding on schedule. Prior to the SIM Initiative, one of the TennCare health plans had implemented such a tool, and the state decided this was an important initiative to implement statewide and across payers. The state is optimistic that the ubiquity of the CCT will enhance its effectiveness in improving care coordination.

Many of the stakeholders with whom the RTI team spoke reiterated that, because the SIM Initiative is still in its early phases, much remains to be seen regarding implementation and impact. Nonetheless, stakeholders and the state are optimistic about the potential for the EOC and primary care transformation initiatives to improve care coordination. Many payers and providers cited the primary care transformation pieces—including PCMHs, health homes, and the CCT—as critical in improving care coordination over time. Other stakeholders were more skeptical about the potential for improvement, citing the required behavioral change on the part of providers and patients.

The SIM implementation process has revealed multiple challenges from the perspective of the state and other stakeholders. The state, providers, and payers all expressed challenges with strained resources. Several state officials stated that they had underestimated how much work SIM implementation really is, and that states need to understand that SIM implementation is a full-time job for everyone involved. Provider and payer stakeholders repeatedly stressed that SIM implementation has created a significant strain on their internal resources. This strain includes the time needed to: (1) attend stakeholder meetings and technical advisory groups; (2) develop internal systems for EOCs, PCMHs, and Health Link; (3) interpret data reports; and (4) provide education and training to providers (when applicable).

Some providers expressed concern that the SIM Initiative presented yet another set of requirements on top of recent regulations like the International Classification of Diseases-10 shift and the Medicare Access and CHIP Reauthorization Act of 2015. Additionally, stakeholders across all categories expressed concern over SIM's aggressive timeline. Stated one payer, "I would not do all of this at the same time. It is a lot of change with the same people managing all of that change, and it is kind of overwhelming."

The RTI team also heard from multiple stakeholders that provider engagement and communication is a challenge in Tennessee, because the SIM Initiative touches several types of providers across the state, requiring extensive and frequent communication using several

modalities. Furthermore, multiple stakeholders said that providers remain unsure about the SIM strategies. In particular, hospitals and some specialists were reported to be skeptical of the EOCs. In some cases, they were skeptical that the correct “quarterback” was chosen for an episode; for example, providers questioned whether the hospital could impact costs for an asthma episode. In other cases, they expressed doubt that the data reports would be used effectively by providers.

Provider, payer, and consumer advocates all expressed concern about the health IT and data analytics capabilities providers will need to participate in the SIM Initiative. Although stakeholders agreed on the great need for increased data transparency and care coordination in the state, many stakeholders felt that the state’s data reports will not be actionable unless providers have the knowledge and resources to interpret them. This will be even more of a challenge for small practices and private practices that may lack the ability to train and hire data analysts.

Although Tennessee is still early in the process of SIM implementation, a few lessons learned have emerged. The state learned early on that trying to implement reform across all payers (Medicaid, commercial, and Medicare Advantage) simultaneously is too much. As a result, the state modified its vision of when different payers will come on line with the reforms. The state also learned the importance of giving payers flexibility in how they achieve the reform goal, because commercial payers operate in a very different environment than public payers. For example, health plans are often third-party administrators for self-insured employers, which raises questions about how far the state can ask them to go with particular reforms.

Finally, Tennessee found that state-led health reform can be an effect modifier for other health reform efforts within the state. A consumer advocate reflected that the SIM Initiative has already served as an effect modifier within Tennessee—by serving as a catalyst for Vanderbilt University’s 4-year, \$28 million Transforming Clinical Practice Initiative grant from CMS, as well as care coordination efforts in Memphis. “I don’t think any of this would have happened without the SIM grant,” she explained. Nearly all stakeholders expressed support for health care system transformation in Tennessee, a state with significant health challenges. Stakeholders expressed eagerness to see how the SIM Initiative will unfold across the state and affect quality, cost, and overall population health.

4.11 Washington

The Washington SIM Initiative is a component of the larger Healthier Washington project. The overall goals of Healthier Washington are to build the capacity to move health care purchasing from volume to value, improve the health of state residents, and deliver whole-person coordinated care. Washington state government uses the phrase “first mover” to refer to the actions the state is initiating on its own as a health plan payer and administrator in its implementation of the SIM Initiative. The state is taking the lead in health care reform by

making changes in Apple Health (the state's Medicaid program) and the Public Employee Benefits Board (PEBB) program, which provides health care coverage for state employees and their families. Through these programs together, the state purchases health care for 2.2 million covered lives (in a state population of 7.06 million), spending \$10 billion per year.³¹ A key contextual characteristic of SIM implementation is that many of the innovative transitions are being initiated gradually over time by region, building on pre-existing efforts, rather than statewide all at once. Through the SIM Initiative, Washington is making investments in several areas.

First, the state has established nine regionally organized Accountable Communities of Health (ACHs) with the goal of bringing together stakeholders from multiple health sectors with a shared interest in improving health and health equity—to determine priorities for regional health improvement projects and implement these locally driven projects. Each ACH establishes its own governing structure and priorities, and to date, two regions have launched pilot projects. Stakeholders expressed concerns about the viability of the ACHs, including the following: (1) their legal structure and role in receiving and disbursing funds; (2) limited administrative funding; (3) reliance on a largely volunteer effort to convene multiple parties; and (4) lack of direct participation by consumers, including the local tribal communities.

Another SIM investment is the practice transformation support hub, which is a portal for resources for providers and an avenue for providing practice transformation assistance. The state conducted a series of listening sessions across the state to learn about ongoing practice transformation activities and where the hub could most help providers. To promote these activities, two requests for proposals have been released. The first solicits a regional health connector to coordinate clinical-community linkages. The second seeks a practice coaching vendor.

Washington also has developed four models for payment redesign that are in various stages of implementation. Payment Model 1, Early Adopter of Medicaid Integration, is integrating Medicaid payment and delivery of physical health services with mental health and substance abuse services. A goal is to reduce ER visits and hospital stays among behavioral health patients by delivering more continuous, whole-person care. Payment Model 1 is implemented only in the Southwest Washington region, with a legislative requirement of full integration statewide by 2020.

Payment Model 2, Encounter-Based to Value-Based, is a VBP methodology for Medicaid enrollees that individual FQHCs and rural health clinics can choose to adopt. A key goal is to determine whether greater financial flexibility for these two types of organizations will promote

³¹ Teeter, D. (2016, June 21). Increasing purchasing power in Washington State. *Health Care Payment Learning & Action Network*. Retrieved September 2, 2016, from <https://hcp-lan.org/2016/06/increasing-purchasing-power-in-wa-state/>.

innovative care delivery models (e.g., email, telemedicine) and improve access to services. Although discussions have begun on the Payment Model 2 development, it is still in the early stages, and stakeholders expressed frustration with the slow pace.

Payment Model 3, Accountable Care Program and Multi-Purchaser, is an accountable care model for state employees and their families. Two insurance plans (University of Washington Medicine Accountable Care Network and Puget Sound High Value Network) became options for state employees in five counties in January 2016. While state officials were pleased with the number of initial enrollees, they told the RTI team that total enrollment in both networks must rise over time for the plans to be sustainable.

Model 4, Greater Washington Multi-Payer, is an integrated, multi-payer database strategy rather than a payment model. State officials will contract with a lead organization to develop the database to link information on Medicaid, public employees, and commercial marketplace enrollees, so providers can access consistent information on their patients. At the time of the 2016 site visit, the contracting process was not completed.

Washington has initiated the Analytics, Interoperability, and Measurement (AIM) strategy, bringing together ongoing health IT and data infrastructure efforts—connecting state data with clinical data systems to create a clinical data repository that can assess population health. An AIM director, hired in April 2016, has begun developing the analytic data infrastructure and AIM’s communication plan—with the goal of effectively working with stakeholders, so the state is viewed as a partner.

The Governor’s Office provides the policy direction for the SIM Initiative, including the investment areas. Additional leadership is provided by the director of the Health Care Authority (HCA) and the secretaries of the Department of Social and Health Services and the Department of Health. HCA administers the Medicaid and PEBB programs and leads development of the payment reform models. The Department of Social and Health Services provides expertise for the Medicaid integration of physical and behavior health. The Department of Health leads the practice transformation support hub and population health activities. Day-to-day coordination is housed in HCA. The 55-member Health Innovation Leadership Network advisory group provides ongoing stakeholder guidance for the SIM Initiative from providers, business, health plans, unions, consumer and community representatives, local governments, state agencies, tribal entities and others.

Care coordination and improved access to needed health care were viewed as critically important by multiple stakeholders. In relation to the newly insured and poor minority Medicaid beneficiaries, clinic providers expressed that many of these patients are not healthy, and often come to primary care clinics in need of more than just preventive services. Rather, these patients need referrals to specialty services; however, providing access to specialists and dental care is

challenging. Some clinic providers expressed concerns that reforms emphasizing “paying for value” and not volume could worsen patients’ access to getting the specialized services they need—if providers are incentivized to avoid high-cost patients with poor health.

Connecting health care delivery to community resources was an explicit expectation in Payment Model 1 and the practice hub. Availability of coordinated care differs by community, however. One state official highlighted the need for increased incentives to promote integration in rural communities, which have a less developed local infrastructure and fewer financial resources than urban areas do.

Payers and providers both expressed the need for cautious expectations in relation to the pace of implementing improved care coordination in the commercial market. They anticipate that coordination across payers will be a multiyear effort.

Stakeholders saw improving quality of care as a goal across payment models. They identified transparency as a key component in improving quality of services and patient experience with care. As such, multiple stakeholders, including state officials, saw development of good performance measures as critical across efforts. Prior to the SIM Initiative, a core set of 55 performance measures, developed with stakeholder input, were finalized in December 2014. Behavioral health measures were added in 2016, to complete the first full set of performance measures. As mandated by House Bill 2572, the core measure set is intended to continue to evolve in response to improvements in the science of measurement and state priorities. The Performance Measure Coordinating Committee developed the initial measure set and has met quarterly to consider recommendations for its improvement. The committee will continue to meet through 2017. The practice transformation support hub is intended to provide greater support to providers in helping them improve their understanding of the purpose of the measures.

Population health was held in high esteem by stakeholders, who also noted that population health is not a concept with a uniformly shared meaning. Some think of population health as chronic disease patient populations or a practitioner’s own patient panel, with health improvements in these groups acting to improve aggregate patient health. Others take a wider view beyond clinical care—considering population health within the context of the broader social determinants of health, and bridging the roles of the community and the health care system. The state is developing its Plan for Improving Population Health to guide health improvement strategies, which stakeholders saw as a relevant and useful tool for coordinating various population health efforts, such as prevention, health equity, and social determinants of health. The Healthier Washington common measure set includes population health measures aligned with SIM goals, which interviewees saw as quite helpful.

In Award Year 1, Washington has predominantly focused on building infrastructure, testing models in pilot areas, and gaining input from across stakeholder groups. The state has

initiated new efforts among the populations for which it is a payer, including integration of physical and behavioral health for Medicaid beneficiaries and Accountable Care Networks for state employees and their families. The state is also well under way in developing performance measures. As Washington continues to implement its SIM Initiative, the RTI team will follow the state's progress in expanding initiatives into more geographic areas, including rural communities—reaching agreement with the FQHCs and rural health clinics on payment model reform, expanding VBP to other payer populations, and the willingness of payers to share additional types of enrollee data.

5. Conclusion

The 11 Round 2 Model Test states were either in the first few months of their Award Year 2 or had not started their Award Year 2 during the analysis period (through June 30, 2016) for this annual report. However, each state had a SIM Round 1 Model Design or Model Pre-Test award and had completed at least 12 preimplementation months of its SIM Round 2 Model Test award. Thus, these 11 states had developed designs and plans that provided the RTI team with information on what roles innovative health care service delivery and payment models, policy levers, strategies, plans for integrating population health, and existing efforts would play in their SIM Initiatives.

Common elements across the 11 Model Test SIM Operational Plans include the integration of primary care and behavioral health services, patient-centered medical homes (PCMHs), shared savings payment models, and quality measures. Despite potential obstacles related to sharing behavioral health records, behavioral health and primary care integration is a significant aspect of the state's SIM Initiative in Colorado, Connecticut, Delaware, Rhode Island, Tennessee, and Washington. Seven states included the PCMH model in their SIM awards—by either building upon existing models, expanding availability of the existing model, or implementing new PCMH models. Idaho plans to go a step further in the PCMH concept, by creating virtual PCMHs. Shared savings will take various forms among Round 2 Model Test states. Some shared saving models include only upside risk, while others include both upside and downside risk. In some Round 2 Model Test states, shared savings models are being implemented as part of their PCMH and/or episode of care (EOC) models.

Quality metrics will play a central role in many payment and health care delivery models being supported by the Round 2 SIM Initiatives. For example, quality metrics are being used to certify PCMHs and in the algorithms for determining incentive payments. Quality measures are also part of payment and health care delivery models providers participate in through other existing state and commercial insurance programs. Thus, to reduce provider burden while recruiting their participation in SIM-supported models, many Round 2 Model Test states have already recognized the importance of developing a common set of core quality metrics.

During the RTI team's data collection for this Year 1 annual report, most states were only a few months into their Award Year 2 and had not fully implemented their SIM Initiatives. Some states had requested and received no-cost extensions to their Award Year 1, which further delayed implementation of their SIM Initiatives. Other states had made significant implementation progress. Tennessee had implemented the first two waves of its EOCs. Idaho had started expanding its telehealth capacity to support virtual PCMHs. Colorado had matched 100 primary care providers to transformation support, implemented the integration work of four community mental health centers, and started the rollout of activities under its population health

and health information technology strategies. Washington had commenced its Early Adopter of Medicaid Integration (Payment Model 1) in one region in southwest Washington and its Accountable Care Networks (Payment Model 3) model in five counties.

Stakeholders from all Round 2 Model Test states expressed excitement over the potential for their SIM Initiatives to accelerate statewide health care system transformation and to favorably impact health outcomes, health care use, expenditures, care coordination, and quality of care. At the same time, stakeholders in each state expressed concerns related to potential barriers to success—such as the relatively short test period, provider shortages, and lack of or limited data and data sharing.

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Appendix A: Colorado Site Visit Report

During the 2016 site visit to Colorado, which took place from April 27 through April 29—3 months into Colorado’s SIM implementation—the RTI team held 14 interviews on site in Denver, Colorado, and conducted four more interviews by telephone after the site visit, for a total of 18. The team interviewed state officials, payers, primary care and behavioral health providers, and consumer advocates. The RTI team also conducted four focus groups in Denver—two provider groups (one with primary care practitioners and one with behavioral health providers) and two consumer groups with Medicaid beneficiaries (one among beneficiaries with behavioral health conditions and one among beneficiaries without).

In this appendix, the RTI team provides an updated overview of the Colorado SIM Initiative; describes the current health care context in which it is being implemented; and summarizes major early implementation successes, challenges, and lessons learned. The RTI team also discusses key findings from the site visit interviews and focus groups, organized by major topic area. This appendix includes findings based on qualitative data collected through June 30, 2016.

Further details on the analytic approach are available in *Appendix L*. Information on the site visit interviewees for the state is in *Table L-1*, and information on the provider and consumer focus group participants for the state is in *Table L-4* and *Table L-5*, respectively.

A.1 Overview of Colorado’s State Innovation Model

The goal of Colorado’s SIM Initiative is to improve the health of Coloradans by providing access to integrated physical and behavioral health care services, in coordinated community systems with value-based payment (VBP) structures, for 80 percent of Colorado residents by 2019. Colorado’s approach to meeting this goal is best characterized by “four pillars” of activities:

- ***Practice transformation.*** Colorado will recruit 400 primary care practices over 3 years to transition to care delivery models that integrate physical and behavioral health. Primary care practices will receive practice transformation and clinical health information technology (health IT) facilitation, and access to financial capital to support transformation activities; these practices will also participate in biannual learning collaboratives. Complementing the focus on primary care practice transformation to improve integration, Colorado has funded four community mental health centers (CMHCs) to transform into integrated health homes, which will provide comprehensive, integrated or co-located behavioral and physical health care to children, adolescents, and adults who receive the majority of their care at these mental health centers. This innovation is known as the bidirectional health homes initiative. These mental health centers will participate in shared learning among

themselves. The state still has to decide whether the centers will also attend learning collaboratives with the primary care practices.

- **Payment reform.** Colorado will work with six major commercial health plans in the state and with Medicaid to shift away from predominantly fee-for-service (FFS) payment arrangements and more toward value-based payment arrangements. Through a voluntary memorandum of understanding (MOU), these seven payers have committed to identify and employ value-based payments in the primary care practices participating in the primary care/behavioral health integration initiative. Each payer will be responsible for determining which of the practices will receive value-based payments and for negotiating with each practice what the structure and amount of these payments will be. Each practice will receive value-based payments from at least one payer. Further, payers can also choose to implement value-based payments with other primary care practices not participating in the initiative.
- **Population health.** Colorado’s focus is on community engagement, reducing stigma, and increasing access to behavioral health resources through (1) grants to local public health agencies (LPHAs) and behavioral health organizations (BHOs) to build community coalition and support activities in stigma reduction, as well as promote best practices in mental health screening; (2) development of primary care provider (PCP) education tools on screening for pregnancy-related depression, depression in the general population, obesity, and other behavioral health disorders; and (3) deployment of Regional Health Connectors—individuals hosted in an LPHA or other appropriate community-based organization who will connect practices to public health agencies, social service agencies, and other community partners, to facilitate alignment and coordination of local strategies around behavioral health.
- **Health Information Technology.** Colorado will develop a platform for acquisition, processing, and aggregation of patient-level clinical and claims data. This platform also will have the reporting capabilities to provide practices, payers, and other stakeholders with summary information on quality and costs of care. In addition, Colorado will develop a telehealth strategy that lays the groundwork for a telehealth expansion throughout the state.

Supporting each of these pillars are activities related to engaging consumers in shaping the direction of the SIM Initiative, leveraging policy and regulatory levers to advance SIM activities, developing the workforce to support integration, and evaluating the success of SIM activities.

A.2 Logic Model

Figure A-1, located at the end of this appendix, is a logic model of Colorado’s SIM Initiative. The model depicts the hypothesized relationship between Colorado’s SIM activities and better quality of care coordination, lower health care costs, and improved population health. Column 1 describes the key delivery system transformations—integration of primary care and behavioral health and alternative payment models (APMs)—and the enabling strategies in workforce development, health IT, and population health that are expected to complement

delivery system transformation. Policy levers (Column 2)—such as state legislation, regulations, and certifications; payer collaboratives; practice transformation milestones; quality metrics alignment; technical assistance (TA); and state contracting—are the means by which Colorado will implement its strategies. The success of these levers, in turn, informs revisions to the key strategies in Column 1.

As shown in Column 3, these activities are expected to lead to greater behavioral health integration into primary care, community awareness of behavioral health, integration between medical providers and social services, more patients in value-based payment arrangements, and greater use of clinical and cost data by providers and patients to manage health. As shown in Columns 4 and 5, these changes are expected to improve quality of care and care coordination, reduce per capita expenditures, and improve population health outcomes.

A.3 Implementation Activities

A.3.1 Context of health care system

State officials, providers, and consumer advocates uniformly lauded as the right approach Colorado’s decision to pursue integration of behavioral health in primary care as the hallmark of its SIM Initiative. Colorado was motivated by the high prevalence of behavioral health conditions in the general population, reliance on primary care clinicians to deliver a non-trivial amount of behavioral health care services, and extensive, unmet need for behavioral health treatment.

During the 2016 site visit, many stakeholders—including state officials, payers, and providers—said they had a pervasive sense that Colorado was well-positioned to embark on an ambitious plan of statewide health system transformation to integrate physical and behavioral health with the SIM award. Colorado is leveraging four unique features of its health care landscape to do so. First, Colorado has a competitive mix of payers; at the time of the site visit, 20 carriers offered over 1,000 individual and small group health plans. Second, despite extensive competition among private payers, the payers collaborate to support primary care practice transformation initiatives through the Comprehensive Primary Care initiative (CPCi) described below. Third, approximately 94 percent of the state’s population is insured, and in 2013, Colorado expanded Medicaid to non-pregnant adults up to 133 percent of the federal poverty level. These high coverage rates allowed the state to focus on improved access to and coordination of care, rather than having to concentrate on increasing health coverage. Finally, many interviewees regarded Colorado as a state consistently on the forefront of experimenting with approaches to increase access to high-quality health care. Many also said they considered their efforts to pursue a SIM Initiative award to be a natural fit with the spirit of collaboration and experimentation within the state’s health care system.

Colorado’s initial application for a Round 1 SIM Model Test award was unsuccessful. Instead, the state received a Pre-Test award in 2013, which enabled it to further develop its State Health Care Innovation Plan to (1) integrate behavioral health care into primary care settings, (2) implement payment reform, and (3) develop health IT and data infrastructure to support its transformation activities. Colorado has also pursued participation in a number of health care transformation initiatives, enabling the state to build upon lessons learned in other demonstrations. One stakeholder said Colorado seems to have “the highest per capita innovation awards in the country.” Select initiatives include both federal and state initiatives, as described below.

Federal initiatives

- ***Comprehensive Primary Care initiative.*** CPCi is a 4-year, multi-payer initiative sponsored by CMS that offers enhanced payments, by Medicare and private payers, to PCPs for comprehensive care coordination and care management to Medicare and privately insured patients in seven regions across the United States. Colorado was selected as one of the seven. Many interviewees said they regarded CPCi as foundational to the SIM Initiative, and that CPCi was critical to building trust among the state, primary care practices, and payers. Through CPCi, nine payers (eight private payers plus Medicaid) in Colorado came together to form the Multi-Payer Collaborative (MPC). The MPC has been actively involved in shaping the payment reform component of the SIM Initiative. Many stakeholders said they viewed continued collaboration within the MPC as critical to successful implementation of payment reform.
- ***Transforming Clinical Practice Initiative.*** Through the Transforming Clinical Practice Initiative, a 4-year initiative sponsored by CMS, Colorado’s Department of Health Care Policy & Financing (HCPF) will provide TA to approximately 2,000 clinicians and practices. The initiative’s goal is to improve the way clinicians deliver care by using Practice Transformation Networks—peer-based networks that will provide on-the-ground health IT assistance, practice facilitators for in-practice assistance with the transformation process, regional learning collaborative sessions twice a year, and shared learning platforms.
- ***Evidence Now Southwest.*** Sponsored by the Agency for Healthcare Research and Quality, this initiative aims to build 208 small- and medium-sized primary care practices’ capacity for quality improvement and practice transformation to improve the heart health of their patients. Practices will receive 9 months of quality improvement support from practice facilitators, as well as data collection/electronic health record (EHR) enhancement support from clinical health IT advisors (CHITAs) and connections to community resources through the regional health connectors. Additionally, practices receive a financial stipend, access to online learning opportunities and in-person learning collaboratives, and practice assessments/feedback.

State initiative

- **Accountable Care Collaborative.** The Accountable Care Collaborative (ACC), Colorado's Medicaid primary care case management program, was launched in 2011. Through the ACC, primary care medical providers contract with regional care collaborative organizations (RCCOs) to provide medical home services to Medicaid enrollees. Each of Colorado's seven regions has one RCCO, which connects Medicaid enrollees to providers, social services, and community support. RCCOs also facilitate communication between providers to coordinate care, with the goal of ensuring each Medicaid enrollee has a medical home level of care.

In addition to access to RCCO services, individuals with behavioral health issues are served by BHOs. Physical health services are reimbursed through FFS, while BHO services are capitated. Preparations for ACC Phase II, which begins in early 2018, are currently under way.

In this next phase, Colorado will no longer have separate systems for physical and behavioral health. A single entity, the Regional Accountability Entity, will take over the patient onboarding, data, financing, and other delivery system operations currently operated by RCCOs and BHOs separately. These system changes established through ACC Phase II were designed to support the goals of physical health and behavioral health integration through the SIM Initiative.

In addition to these federal and state Medicaid initiatives, according to stakeholders, private payers have practice transformation efforts under way with many of their provider networks. The drawback to participation in numerous initiatives simultaneously is what many site visit interviewees termed "innovation fatigue." Many interviewees emphasized the need for alignment, coordination, and simplification within the SIM Initiative with other statewide initiatives already under way. State officials acknowledged that coordinating such large-scale endeavors will likely be a continuing challenge throughout the SIM award period.

A.3.2 Governance and program administration

The Colorado SIM Initiative is headquartered in the Governor's Office, with a director and small team of full-time staff carrying out day-to-day operations. The SIM Director has the primary responsibility for regularly updating representatives from the Governor's Office on SIM implementation and progress. Three state agencies share operational responsibilities for the SIM Initiative. HCPF, which houses the state's Medicaid program, plays a critical role. In addition to having contributed to the development of Colorado's SIM proposal, HCPF is the lead agency supporting fiscal oversight of the SIM Initiative. The Colorado Department of Public Health & Environment (CDPHE) leads the public health components of the SIM Initiative, acting as the bridge for LPHA engagement and for technical support given to SIM-participating practices. Within the Department of Human Services (DHS), the Office of Behavioral Health (OBH) has played an active role in the bidirectional integration efforts and, more broadly, on aspects of the SIM Initiative focused on behavioral health providers. All three agencies have representation on the SIM Advisory Board and within the eight SIM work groups (described below). Additionally,

agencies like the Office of eHealth Innovation and the Department of Insurance within the Department of Regulatory Agencies participate—through work groups and interdepartmental engagement—on components of the SIM Initiative, such as health IT and workforce development.

Partnership with nonstate agencies is also a key component of the SIM Initiative. The University of Colorado has an interagency agreement with the SIM office to administer SIM-related primary care transformation facilitation. Similarly, the SIM office has entered into agreements with such organizations as the Colorado Behavioral Health Council (CBHC) and the Colorado Health Institute to administer other SIM activities—including the bidirectional health homes pilot and regional health connectors, respectively. In addition, The Colorado Health Foundation is partnering with the SIM Initiative to provide funding for the Practice Transformation Small Grants Fund (additional details about this fund can be found in *Workforce Development, Section A.3.6*).

The Colorado SIM Initiative leverages several stakeholder groups to inform and operationalize the delivery system, payment models, and enabling strategies. Eight work groups—Consumer Engagement, Evaluation, Health Information Technology and Data, Payment Reform, Policy, Population Health, Practice Transformation and Service Delivery, and Workforce—meet regularly and are open to the public. The work group meetings are a collaborative space for stakeholders to discuss potential SIM activities, share progress on ongoing SIM activities, and receive feedback from other work group members as well as the SIM office. Individuals from community-based organizations, advocacy organizations, state agencies, payers, and health care providers apply to be work group members. Each work group has a chair and co-chair(s). The work groups report directly to the Steering Committee, which comprises the work group chairs and co-chairs. To facilitate inter-work group communication, SIM office staff attend each work group meeting and share information among groups. To ensure transparency of work group activities with the public, work group materials and meeting materials are made available on Colorado’s SIM website. One provider interviewee noted Denver-based work group meetings present an obstacle for Colorado residents in other parts of the state, who may wish to join.

Stakeholders had mixed feelings about the governance structure. Several interviewees questioned whether the SIM office might have been better situated within a state agency that has oversight for a set of SIM activities (e.g., CDPHE, HCPF) instead of residing in the Governor’s Office, because these types of agencies have experience administering programs, and the SIM Initiative was viewed as a program to administer. Other interviewees expressed concern over the role of the SIM Advisory Board and that it is not being used to provide guidance to SIM operations. Advisory Board members have expertise in administering large programs and delivery system transformation, and some felt that the SIM office should leverage this expertise more than it has so far. Still others said that, with the multiple levels of administration, they were

unclear as to who the ultimate decision maker was for key operational decisions—the SIM office, the Governor’s Office, the SIM Advisory Board, or the work groups.

A.3.3 Stakeholder participation

Most state officials the RTI team interviewed regarded providers and payers as the most important SIM stakeholders, because their participation is foundational to delivery system and payment reform activities. Integration of behavioral health and primary care cannot happen without primary care practice participation, and the promise of value-based payments to support integration activities is one motivating factor in a practice’s decision to apply to participate. As one state official noted, integration will not be possible “unless...the primary care practices adopt this as the new model. The only way that they will adopt it is to make sure the payers recognize it and are doing what they can to make this economically viable.” Engagement of the MPC (see *Section A.3.1* for more information on the Collaborative) with the SIM office has been viewed favorably, as it ensures commercial and public payers in the state remain “at the table” and collaborating with Colorado’s SIM team.

Stakeholder participation developed during the initial SIM planning period, with work groups having emerged from the planning process as a team of thought leaders and experts on a particular topic. Once the eight work groups were established, stakeholder interest was so great that the SIM office had to develop a competitive application process for the volunteer, work group member positions. State officials emphasized that work group participation had been critical to the SIM Initiative, providing key guidance and recommendations on next steps.

As the initiative moved from development, to first steps, toward full implementation, the charge of the work groups changed. One state official stated that, at the beginning of the SIM award, “there were formal processes for the work group that were very task-oriented,” but that recently, the work groups have become more “nebulous.” More than one interviewee (across different stakeholder categories) explicitly identified the departure of the SIM Director in February 2016 as a major cause for this change, which they described as moving from fewer directives to more open discussion about how to proceed. This shift was described as an opportunity (as work groups were now able to self-direct actions and decisions), but also a challenge (as the lack of high-level directives from the SIM office sometimes led to ambiguity). One consumer advocate said the absence of clear direction made it unclear whether the work group’s charge was to provide a recommendation versus a decision to the SIM office.

Perspectives on the challenges affecting stakeholder engagement were mixed. As mentioned, some felt there was only limited room for work group engagement of providers and consumers outside Denver. A small number of state official stakeholders were concerned that the SIM office was too focused on responding to all feedback, and that a more efficient use of time would be to prioritize responses to focus on issues of immediate concern.

Interviewees' responses to questions about the state's receptivity to stakeholder feedback and work group efficacy also varied. Consumer advocates felt they were able to influence the evaluation process to weigh consumer engagement more heavily. Providers said there was limited opportunity to share feedback with the SIM office. However, they also noted that when providers were able to find an opportunity to participate, the SIM office took their input into account.

A.3.4 Delivery systems and payment reforms

The Colorado SIM Initiative supports two major delivery system reforms focused on integrating behavioral health and primary care services. First, Colorado will select 400 primary care practices over the course of 3 years to integrate behavioral health into their primary care settings, known as "primary care practice transformation." Second, Colorado selected four CMHCs to pilot the bidirectional health homes initiative described above. The primary care practice transformation initiative is based on a multi-payer agreement to support the integrated practices with value-based payments. The bidirectional health homes pilot is currently supported by Medicaid through the ACC contracting, as well as by SIM funding administered by the CBHC.

Primary care practice transformation. Selection of the first 100 practices to participate in integrating behavioral health services launched on February 1, 2016. Of the 179 applications, the state chose 100 practices¹ to reflect geographic diversity, a range of experiences with integration, variety in practice size and ownership (e.g., hospitals, health systems, independent practices, rural health centers, Federally Qualified Health Centers), representation of underserved populations, and experience with practice transformation (e.g., through participation in CPCi).

Practices will have to meet 10 practice transformation milestones based on CMS's CPCi Milestones and Thomas Bodenheimer's "10 Building Blocks of High Performing Primary Care."² Some milestones focus on better consumer engagement; others focus on health IT infrastructure, team-based care, population management, and improved access and care coordination. As practices achieve their milestones, participate in learning collaboratives, report data, and process improvement plans, they can receive up to \$5,000 for achieving these milestones. The SIM Initiative is also supporting primary care practices by providing practice facilitators (i.e., transformation coaches) based at Practice Transformation Organizations (PTOs). Each of 17 competitively selected PTOs will deliver either customized practice support or CHITAs, or both. The coach and the practice will jointly design improvement plans based on milestones for which the practices see the most value and room for growth; the CHITAs will assist the practice with data analytics to support practice transformation. At the time of the 2016

¹ Colorado State Innovation Model. (2016). *SIM practice transformation*. Retrieved from <https://www.colorado.gov/healthinnovation/sim-practice-transformation>.

² University of Colorado. (n.d.). *Practice milestones for feedback*. Retrieved from <https://drive.google.com/a/state.co.us/file/d/0BxUiTIOwSbPUQVpYTVhRQjllUEk/view?pref=2&pli=1>.

site visit, practices, their PTOs, and the CHITAs were only beginning to meet and devise a plan for moving forward. The Consumer Engagement work group has produced a template for practices to use with patients, to communicate and frame the integration-related changes practices are making.

Bidirectional health homes pilot. Selection of the four CMHCs to participate in the bidirectional health homes pilot took place in November 2015.³ Through the SIM award, this pilot program has an anticipated total funding stream of \$1,212,000 (\$303,000 annually for each of the four years). Each health home will be required to meet the following requirements. The pilot sites must integrate PCPs directly into the CMHC setting and provide core activities in four target areas (care coordination, chronic condition management, comprehensive transitional care, and individual and family support services). The pilot sites also must identify areas where private and public insurance are not aligned with mental health parity principles, and submit reports guiding HCPF and the Department of Insurance through changes to support parity. At the time of the 2016 site visit, whether the CMHCs would attend learning collaborative activities with the primary care practices, in addition to attending their own learning sessions, was not clear.

Alternative payment models. The transformation work of the Cohort 1 practices is expected to be partially supported by Medicaid as well as by private payers in the state, all of which have agreed to use APMs that reimburse value rather than volume. State officials referenced the Health Care Payment Learning and Action Network (LAN) framework and cited a goal of Category 3 or 4 APMs.⁴ The SIM office will require payers to report on which LAN category best aligns with their proposed payment model (Category 1 = FFS with no link to quality and value; Category 2 = FFS with a link to quality and value, Category 3 = shared savings or risk built upon an FFS platform, and Category 4 = population-based payment). The SIM office will leave up to the payers the specifics of the actual payments they will make to practices.

In February 2016, six of the nine major private insurers agreed to participate in the SIM Initiative by reimbursing Cohort 1 practices and practices in future cohorts using APMs.⁵ A state official called this a “monumental achievement for the state of Colorado”; a consumer advocate agreed that, for the entire SIM Initiative, “at the community level, having health plans at the table has helped achieve tremendous accomplishments.” Overall, state officials are pleased with the engagement of private insurers in the SIM Initiative. However, a few interviewees expressed concern about (1) whether private payers will truly follow through with APM implementation,

³ Colorado State Innovation Model and Colorado Behavioral Healthcare Council. (2015, November 3). *Colorado SIM office announces four bi-directional integrated health home sites*. Retrieved from <https://drive.google.com/file/d/0BxUiTIOwSbPUN2Y3WVYzRnI4TFE/view>.

⁴ Health Care Payment Learning & Action Network. (2016, January 12). *Alternative payment model (APM) framework: Final white paper*. Retrieved from <https://hcp-lan.org/workproducts/apm-whitepaper.pdf>.

⁵ The payers include Anthem Blue Cross Blue Shield, Cigna, Colorado Choice, Kaiser Permanente, Rocky Mountain Health Plan, and United HealthCare.

and (2) how the state can verify APMs that private payers consider proprietary. They cited lack of prescriptive guidance on what the APM should be as a possible reason why payers may not implement the kind of payment reform necessary to effect meaningful change. For example, the APM framework did not specify exactly what payers would be asking practices to do for the alternative payment, and the framework did not specify that the APM had to be different from how the payer already reimburses the practice. Therefore, according to some interviewed stakeholders, the agreement to participate did not necessarily “mean anything” to some payers.

After the state selected the 100 practices to participate in Cohort 1 practice transformation in March 2016,⁶ the participating payers chose from that list the practices they will support. Each payer will establish its own APM with each primary care practice, and each payer has signed a MOU with the SIM office attesting to their willingness to participate in the SIM Initiative by providing APMs. Payers also are free to apply different APMs to different practices. Of the 100 practices, as reported by a state official, 41 are receiving support from three or more private payers (12 from 5 payers and 24 from 4 payers), 46 from two or more private payers, and all from at least one private payer in addition to Medicaid. At the time of the 2016 site visit, practices were being notified of these selections; for example, one provider interviewee confirmed receiving letters from both a private payer and the SIM office. Private payers may also choose to apply APMs to practices outside the practice transformation cohort.

Providers said they felt cautiously optimistic about the multi-payer financial support for primary care practice transformation, but providers also voiced some concerns and confusion. Decisions about APMs were made by payers and the SIM office without provider stakeholder input, due to antitrust or business concerns. As a result, the expectations of providers and payers about the extent of financial support through APMs may not align—with providers expecting more support than they may be given, and payers needing to align their SIM commitments with other initiatives and priorities within their health plans. For example, some interviewees said they were unclear about whether Medicaid would support practices with an APM that was different from their payment methods under the ACC. Several state officials acknowledged the confusion among providers, noting that one lesson learned was the need for better communication at the outset. Providers needed more clear information from the SIM office about how the APMs would work and notification that the details of the APM would have to be negotiated directly between a payer and a practice. Payers and providers also needed more clear directives about the types of information each would need to negotiate a final APM (e.g., beneficiary lists, provider tax identification lists).

Private payers are not yet engaged in the financial support of bidirectional health homes. One provider noted this as a missed opportunity for bending the cost curve because, although the

⁶ Colorado State Innovation Model. (n.d.). *SIM office announces first cohort of primary care practices*. Retrieved from <http://myemail.constantcontact.com/First-Cohort-of-SIM-Practices-Announced.html?soid=1102839655460&aid=W2L1uGEXjj8>.

bidirectional health homes pilot is small, the CMHCs serve high-cost populations with much higher than average health care utilization.

A.3.5 Health information technology and data infrastructure

Colorado is using SIM funding to build a more advanced health IT system on an already rich data infrastructure. Pre-existing key components of the state's data infrastructure include the following:

- An all-payer claims database (APCD) that includes Medicare, Medicaid, and commercial claims data
- Two health information exchanges that connect hospitals, physicians, behavioral health centers, medical laboratories, and the state health department to a centralized data exchange
- Telehealth sites

Through the SIM Initiative, Colorado implemented a quality measures reporting tool (QMRT) to be used in the early stages of the SIM Initiative for primary care practices to report quality measure data. With SIM funding, Colorado will expand on QMRT to develop the quality measures reporting tool + (QMRT+)—a more refined centralized data hub that will be used to collect, quality check, store, aggregate, and report clinical quality measure data collected through providers' EHRs. QMRT+ also is expected to link to the APCD, to facilitate cost-of-care aggregation and reporting for providers, payers, and the public health community. As of the 2016 site visit, no vendor had been selected to build QMRT+. Many stakeholders interviewed considered building a longer-term solution for data aggregation and reporting to be a monumental undertaking.

Colorado interviewees shared a general sense that the state was well positioned to successfully implement a centralized data hub, but not without challenges. The first challenge they noted is the considerable effort that must go into standardizing data from multiple EHRs across the many participating primary care practices. Each practice has its own EHR, and each will need to interface with QMRT+. Developing a data hub that can collect information from multiple EHRs is a complicated, time intensive endeavor. The second challenge interviewees discussed is building a centralized data hub (QMRT+) that stakeholders recognize as having long-term value. The state is very wary of building a platform no one will use after Award Year 4, so Colorado is investing time and energy into developing "use cases" that outline how potentially interested providers and health plans can use the platform.

Using SIM funding, Colorado also has developed an online practice assessment tool known as the Shared Practice Learning and Improvement Tool (SPLIT), which will be used by primary care practices to record progress in reaching their practice transformation milestones. The expectation is that the SPLIT tool will serve as a data warehouse of activities undertaken to

promote primary care/behavioral health integration. All participating primary care practices, PTOs, CHITAs, SIM staff, and regional health connectors will be able to access the information stored in SPLIT to assist in integration efforts. Colorado anticipates refinements to the SPLIT tool over the course of the SIM Initiative to improve the user interface, generate reports, and potentially integrate with other data systems.

A recent advance was the 2015 creation, by executive order of the Governor, of the Office of eHealth Innovation to develop policies, procedures, and technical approaches to enhance the state's health IT network. An e-Health Commission also was created to provide guidance to the Office of eHealth Innovation. The SIM office is engaging with that Office to align efforts to advance the state's SIM health IT priorities.

The telehealth strategy is already under way, and Colorado has contracted with Spark Policy Institute to develop a statewide strategy to implement telehealth. Beginning in 2017, insurers in Colorado will be mandated to reimburse both the originating provider (if a visit with the originating provider precedes the telemedicine consultations) and the distant provider for telemedicine visits. All stakeholders viewed the path to telehealth expansion as a “good thing.”

Multiple state officials noted that there are not enough resources in the SIM office to devote the necessary time and expertise to SIM-related health IT issues—requiring the SIM office to rely on assistance from other thought leaders in the state (e.g., members of the e-Health Commission) to help them formulate and move forward health IT-related activities. Some state officials and stakeholders suggested that communication between the work groups should have been coordinated much earlier, so that each had input into the other's ideas related to quality measure reporting and monitoring, as well as the health IT data available to generate those measures. There was also a sense from at least one state official that there could be great gains from shared learning among the various SIM Model Test states interested in building data aggregation platforms to further transformation efforts.

A.3.6 Workforce development

During the RTI team's site visit, more than one state official acknowledged that Colorado has a challenging workforce shortage. Mental health provider shortages (e.g., too few psychiatrists and psychiatric hospital beds) are a particularly pressing issue—a sentiment echoed by state officials, providers, and other stakeholder interviewees. Colorado's primary care behavioral health integration efforts are particularly vulnerable to this issue; as one interviewee noted, “many perspectives and parties are concerned about work force ... are there enough providers to be integrated?” By leveraging general funds and foundation dollars,⁷ the state has been able to expand placement and loan forgiveness programs for health workforce members. However, recruitment, retention, and sustainability continue to be difficult, particularly in rural

⁷ These general funds and foundation funds were not part of Colorado's SIM funding.

regions of Colorado, which has made workforce development and retention an area of focus for the SIM Initiative.

Although Colorado did not request SIM funds to address workforce specifically, the SIM Initiative does include workforce development activities to build the skills of the existing workforce. For example, as discussed, the SIM Initiative has a work group dedicated to workforce development, which is currently working with interested parties to identify common priorities. One state official raised the development of core competencies for behavioral health as a potential priority. The work group also will be involved in creating job descriptions for other components of the SIM Initiative (e.g., for the regional health connectors). One payer noted that the state has expanded the scope of practice for dental hygienists and nurse practitioners, and said that leadership at the Colorado Department of Labor and Employment may be interested in creating further career paths for other types of health care workers affiliated with the behavioral health sector. One provider identified alternative workforce strategies (e.g., services, such as transportation, provided to individuals by their peers) as potential areas for the SIM Initiative to explore, but emphasized that these services would need to be billable to a payer for reimbursement.

The primary care practice transformation component of the SIM Initiative involves some overlap with workforce issues. For example, the SIM-supported Practice Transformation Small Grants Fund is open to practices participating in the first transformation cohort. The small grants program has two sources of funding, one from the SIM Initiative, the other from The Colorado Health Foundation. The SIM funds can be used to support the training and onboarding of clinical staff, while The Colorado Health Foundation funds can be used as seed funding to support the hiring (or contracting) and initial salary expenses of behavioral health clinicians.

DHS is participating in the National Governor's Association Health Care Workforce Policy Academy and receiving TA with workforce development. One state official specified that DHS is looking at strategies to better compensate health care workers, primarily in mental health care settings. The SIM Initiative is using learning collaboratives and provider education within its practice transformation components (in the primary care cohort practices as well as in the bidirectional integration pilot practices), which may offer opportunities to discuss workforce development.

A.3.7 Population health

From model design to early implementation of population health activities under the SIM Initiative, Colorado follows the general recommended definitional framework for population health.⁸ According to state official interviewees, population health activities under the SIM Initiative are designed to align with and impact traditional clinical approaches. These activities

⁸ Kindig, D., Asada, Y., & Booske B. (2008). A population health framework for setting national and state health goals. *Journal of the American Medical Association*, 299, 2081–2083.

focus on community engagement, reducing stigma, and increasing access to behavioral health resources. Under this guiding framework, the state has identified three major strategies:

1. Grants will be given to LPHAs and BHOs to build community coalition and support activities in stigma reduction and promotion of best practices in mental health screening. At the time of the 2016 site visit, requests for applications had been issued to release funding to LPHAs and to collaborative organizations to address behavioral health issues.
2. CDPHE will partner with OBH to develop and roll out provider education tools on screening for pregnancy-related depression, depression in general populations, obesity, and other behavioral health disorders.
3. Colorado will deploy a new workforce of 21 regional health connectors. These will be hosted in an LPHA or other appropriate, community-based organization and will facilitate alignment and linkage among clinical service delivery, local public health efforts, and broader community resources in their region of responsibility. This was the most well-known population health strategy to stakeholders outside state agencies. All stakeholders who knew about the regional health connectors understood that, in design, this approach is distinctly different from traditional care coordination movements that focus on navigating patients through the health care service delivery system.

At the time of the 2016 site visit, each of the strategies was still in the early stages of implementation, and detailed strategies and goals around population health were not well understood by stakeholders outside the relevant government agencies overseeing these activities.

A.3.8 Technical assistance and other support resources

Overall, state officials expressed having had a positive experience engaging with the SIM program team. Those who had received TA from CMS found it particularly helpful. Highlighted in the site visit interviews were the crosswalks and state-to-state sharing available through CMS, as well as assistance with memos and other materials used during development of the Operational Plan. However, one state official and one consumer advocate said that, more than once in their experience, the process for CMS to approve contracts issued by the Colorado SIM office had taken several months.

A.3.9 Progress, challenges, and lessons

While Colorado is still in the beginning phases of implementation, several key components of its SIM Initiative are already under way. The 100 practices in the first practice transformation cohort have been selected, payers have agreed to participate in supporting practice transformation, and connections between practices and payers are beginning. The four pilot CMHCs have been selected. LPHAs and collaboratives were applying for funding through the population health initiatives, and stakeholder engagement via the work groups continues to be robust.

However, the state has encountered challenges from SIM implementation through June 2016, including:

- ***Staff retention.*** The SIM Director left her position in February 2016. The SIM office also has had staff turnover, with the remaining core staff numbering about four individuals. In addition, the state has had several different project officers at CMS. Such turnover causes staff fatigue for those remaining. Despite the turnover, however, many interviewees felt the SIM office has been responsive and diligent in keeping implementation activities on track.
- ***Placement of the State Innovation Model office.*** Several state officials discussed the decision for SIM leadership to sit in the Governor’s Office as a challenge. Several interviewees noted that there might have been efficiencies gained in locating the SIM office within an existing state agency already extensively involved in the SIM Initiative.
- ***Sufficient resources.*** Interviewees’ answers varied considerably when they were asked about the resources available for the state to implement and test its SIM Initiative. Many state officials noted workforce and consumer engagement, in particular, as unfunded areas that may present challenges during implementation. Others emphasized that the SIM office has been successful in leveraging non-SIM funds (through work with foundations) and resources available through pre-existing integration work in Colorado. A majority of those interviewed, however, shared concerns about the sustainability of SIM-funded activities after the federal SIM money is gone.
- ***Lack of Medicare’s participation in the State Innovation Model Initiative.*** Several state officials and other stakeholders noted the increased influence the SIM Initiative would have among payers if Medicare were “at the table,” providing value-based payments to the primary care practices to support behavioral health integration. Colorado has requested Medicare’s participation in its SIM Initiative, and the state and CMS have had conversations about the best approaches for Medicare involvement. Currently, the state is looking toward CMS’s newly released Comprehensive Primary Care Plus (CPC+) initiative as one possible mechanism to gain Medicare participation.
- ***Aligning expectations between payers and providers.*** Primary care practices participating in the practice transformation initiative were notified by the Colorado SIM office of the extent of payer support only after applying to participate. Some site visit interviewees observed that some practices may have had expectations about the level of support needed to undergo transformation that may not match the actual level of reimbursement offered. State officials reported hearing anecdotally that some practices were unhappy with the APMs offered by payers. One consumer advocate noted that, if practices do not believe they are being adequately reimbursed for their behavioral health integration efforts, practice support for this delivery system reform could wane.

State officials reflecting on lessons learned often discussed the necessity of understanding the wider health care landscape and state context. Some explained, for example, that it is

essential to grasp the dynamics of the health care market to understand which players “stand to gain or lose from an integrated model.” Moreover, when pursuing change, they said, it is critical to understand how the SIM Initiative will change the entire health care landscape—not simply within the parameters of the project but “for decades in the future.” Many entities within Colorado have expertise and vested interests related to many of the proposed SIM activities. Bringing all interested parties to the table to collaborate and generate actionable next steps to implement the SIM Initiative necessitates negotiation of expectations about each entity’s role. As some interviewees noted, a lot of funding is attached to the SIM Initiative, and with that level of funding come real challenges negotiating how to allocate those dollars.

From an operations perspective, state officials noted the importance of communication. For example, there has been staff turnover in the communications manager position in the SIM office—a position that is critical to maintaining up-to-date communication with stakeholders requesting presentations, work groups, the Governor’s office, and state legislators. State officials and providers recognized the need for better communication between the SIM office and the primary care practices applying to participate in the practice transformation initiative on exactly what the initiative is and is not—in particular, that it is not an extension of CPCi.

A.4 Statewide Changes

This section discusses stakeholders’ perspectives regarding which SIM Initiative activities are expected to impact desired outcomes, and what those impacts might be.

A.4.1 Health care expenditures

Colorado’s SIM goal is to improve the health of Coloradans by providing access to integrated physical and behavioral health care services in coordinated systems, with value-based payment structures, for 80 percent of Colorado residents by 2019. The state’s primary means to achieve the value-based payment goal is to encourage payers in the MPC to support primary care practices with APMs. During the site visit, most interviewees did not mention concerns about the current costs of care in Colorado, and almost none discussed explicit goals to reduce costs of care. However, one payer and one state official did note that, if coordination and integration goals are achieved, payers can expect some reduction in the total cost of care based on past experiences with accountable care initiatives. The SIM Initiative outlined a plan to analyze claims data from Colorado’s APCD to provide reports back to participating primary care practices about the total costs of care for their patients. Thus, although not operational as of the site visit, stakeholders said they expect that practices will be given tools to help analyze their performance on cost metrics.

Site visit interviewees had mixed expectations about the feasibility of reaching 80 percent of residents through an integrated system supported by value-based payments. Some noted that estimating the feasibility of the 80 percent goal depends on how those touched by the system are

counted. Others were simply suspicious of the state's ability to reach that many people, especially if Medicare is not participating.

A.4.2 Health care utilization

Stakeholders noted significant pre-SIM Initiatives designed to change patterns of health care utilization, including CPCi and the prior state and multi-payer homegrown initiatives (including Medicaid's ACC program and payers' medical home programs). With respect to health care utilization success under the SIM Initiative, stakeholders said they expect increased utilization of primary and behavioral health care services (especially in underserved and rural areas) and decreases in hospital and emergency room (ER)-related services. The Colorado SIM Initiative selected seven utilization metrics to be measured quarterly by participating primary care practices and benchmarked against utilization targets. However, providers and state officials both noted significant barriers to moving toward more efficient health care utilization under the SIM Initiative—the most notable barrier being more demand in the health care system than there are licensed professionals. Many stakeholders mentioned the primary care and behavioral health provider workforce shortage, with one rural PCP particularly emphasizing a large void in the market for behavioral health in rural environments. Increased utilization of behavioral health and primary care services is predicated on an adequate workforce. If the SIM Initiative is trying to build bridges between providers to integrate care, as one state official put it, one must hope they are not “bridges to nowhere.”

Another barrier a consumer advocate noted was the challenge of a low rate of patients, diagnosed in primary care with mental health conditions, who follow through on referrals to behavioral health providers. This advocate also noted that—even though campaigns and billboards in Colorado are designed to reduce stigma and encourage patients to follow through on referrals—referral follow-through is still the “most profound barrier.”

Multiple stakeholders, as well as consumer and provider focus group participants, noted models of alternative access to care (e.g., use of non-traditional office hours, patient portals). Telehealth is being used for behavioral health services through some mental health centers, and the state is looking at ways to expand telehealth through SIM activities. Payment for the program has been resolved, and there are no regulatory impediments. Multiple stakeholders noted that Colorado is one of the first states to have statutes and regulations guiding the use of, and payment for, telemedicine. In addition, stakeholders noted E-visits (e.g., use of patient portals for patients to ask questions and providers to deliver follow-up care) as possible means for expanding utilization. However, these same stakeholders had the opinion that, without payment reform to reimburse providers for this service, use would continue to be limited. Stakeholders also noted the opportunity under the SIM Initiative to improve the chasm between clinical delivery system and community-based wellness and prevention services.

At a macro-level, stakeholders noted that the state’s ER visit rate is rising; in fact, consumer focus group participants reported their reliance on the ER and hospital use. In terms of reducing over-utilization of specific services, at least one provider noted that there should be a high-utilizer component in the SIM Initiative if the state wants to bend the cost curve—viewing this as an opportunity the Colorado SIM Initiative has missed. Another provider noted that, from a systems perspective, incentives are misaligned when PCPs are tasked with trying to reduce over-utilization of high-cost services, while significant profits still can be made in that same health system from ER visits and hospital admissions.

A.4.3 Care coordination

Care coordination is among the primary goals of the Colorado SIM Initiative. A key objective is “to create a coordinated, accountable system of care that will provide Coloradans access to integrated primary care and behavioral health in the setting of the patient’s medical home.” State officials, providers, advocates, and other key stakeholders interviewed all held care coordination in very high esteem. Most—especially state officials and providers—agreed that care coordination, particularly between primary care and behavioral health, is rightly an important SIM Initiative focus.

The SIM components most frequently cited by site visit interviewees as potentially having the largest impact on care coordination were (1) the SIM Practice Transformation efforts to support primary care practices in integrating physical and behavioral health, and (2) the bidirectional effort to embed primary care in CMHCs. State officials, payers, and providers, although hopeful and positive, all expressed skepticism regarding the ability of the SIM Initiative to have a significant impact on care coordination. Key concerns fell into four areas: workforce shortage issues, insufficient or unsustainable payment mechanisms, data exchange limitations, and the complexity of multiple care coordinators. Interviewees’ comments in these areas include the following:

- **Workforce.** Site visit interviewees noted several critical workforce issues that could impact the SIM Initiative:
 1. State officials and providers interviewed all noted a shortage of PCPs and behavioral health providers in the state, with the shortage felt most acutely in rural and frontier regions. Integrating behavioral health when there are no available behavioral health providers to refer patients is seen as a critical limitation to Colorado’s SIM strategies.
 2. Some providers, particularly behavioral health providers, do not accept Medicaid and/or any private insurance, which presents access barriers to individuals not able to pay out of pocket for care.
 3. In situations where primary care and behavioral health will co-locate, there are cultural differences in practice patterns to overcome if integration is to be successful. For example, the time allotted to see a patient varies tremendously

between primary and behavioral health care, so integrating them into the same practice poses practice workflow challenges.

4. In an integrated setting, decisions need to be made by the care team over which provider (the PCP or the behavioral health provider) takes the lead in deciding a patient's care plan.
5. Overcoming "practice protectionism" will take time. This protectionism stems from the desire to remain the "medical home" for patients, and not let additional providers into the practice or refer them for more care outside the practice.

Primary care and behavioral health providers who were interviewed reported that training is critical for both types of providers to understand how to work and function effectively in an integrated setting. For those that will integrate through co-location, behavioral health providers noted that PCPs are getting more comfortable with having behavioral providers in their practices. The collaborative learning activities should provide a forum for some of this training. See **Section A.3.6** for additional details on Colorado's activities to address workforce concerns.

- **Financial incentives.** Some interviewed PCPs observed that care coordination can be hampered when coordination services are not billable to an insurer. PCPs and behavioral health providers both noted, often in frustration, that they may not be able to bill for nontraditional care coordination services. At least one provider noted his or her practice applies for grants to be able to provide services not traditionally reimbursed by insurers. One stakeholder said that payment reform is a necessary precondition before pursuing models of alternative access and integration; payment reform gives providers the flexibility to provide services not traditionally paid for by insurers.
- **Data sharing.** Many state officials noted the need for connected information systems or access to shared data as a pre-requisite/necessary condition for integrated care coordination. However, multiple stakeholders raised two key issues. The first is the impact of *Code of Federal Regulations 42 Part 2*⁹ as a regulatory barrier limiting data sharing for substance abuse data. Colorado's SIM Initiative is exploring strategies for obtaining client consent for sharing such data. The second issue is a pervasive sense that providers need data systems that produce data and reports a provider can act on in meaningful ways.
- **Too much coordination.** With a number of significant health care innovation initiatives in process, many with a care coordination component, consumers can be overwhelmed. Consumer advocates expressed a need for coordination of care coordinators for a single patient—as one state official put it, "someone to coordinate the coordinators."

When asked what defines success in relation to care coordination, interviewees gave several answers. "We want the right services offered at the right time for the patients who need

⁹ U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (n.d.). *Applying the substance abuse confidentiality regulations*. Retrieved from <https://www.samhsa.gov/health-information-technology/laws-regulations-guidelines>.

them.”¹⁰ No provider will be able to say “I can’t help you” to a patient because they will not get paid for it. Patients will not be “stuck” between systems in which they don’t fit. Providers interviewed expressed the hope that practice and system transformation means they will be able to provide care or refer patients to care, regardless of the specifics of their conditions. Interviewees also described breaking down siloes, overcoming the barrier of “you do behavioral health and we do primary care, don’t play in our backyard.” Despite having relatively clear and homogeneous concepts of what success would look like in relation to care coordination under the SIM Initiative, however, stakeholders did not express any clear understanding about how care coordination would be measured.

A.4.4 Quality of care

Colorado’s hypothesis around quality of care is that it will be improved by the integration of physical and behavioral health care in alignment with the other SIM strategies. Focus group providers noted that the quality of care in the current health care system has already been improved by extending service hours and the emergence of care coordination, as well as EHR systems. However, one rural provider noted that, in rural and frontier communities across the state, access to needed care remains challenged by geographical constraints and insufficient provider supply. The latter, they say, is particularly compounded by independent providers’ unwillingness to bear the administrative burden of billing health plans for services that are not well reimbursed.

PCP and behavioral health provider focus group participants, as well as some provider stakeholders, noted a definite gap in quality—that PCPs shy away from screening for behavioral health concerns, because they are unsure how to treat such conditions if screening identifies them. Some providers described this mentality (of leaving the task for someone else more appropriate for the job) as counterproductive to true integration of physical and behavioral health. Some state officials also noted that, if implemented successfully, SIM’s integration activities have the potential to change this mindset, and provide primary care practitioners the resources to successfully screen patients, treat them if able, or refer them to behavioral health providers for more intensive treatment.

Echoing urban providers’ generally positive feedback about the improved health care system, focus group consumers from one urban area generally voiced satisfaction with the care they obtain from their PCPs. Nevertheless, they shared difficulties in navigating other parts of the health care system beyond their PCP. Consumers reported being able to obtain an appointment to see their PCPs the next day, but needing to wait at least a month to get a specialist appointment. Furthermore, consumers said they feel limited in their ability to contact providers for quick questions about their medication and other issues outside an appointment.

¹⁰ This stakeholder felt that ideally, they would like to see care coordination not being limited to just behavioral health but instead “health of the whole person.” Another stakeholder put it as “aligning incentives so that all providers feel responsibility and have opportunity.”

Although large practices have adopted various forms of patient portals, and providers described some value in using them to share information with their patients, the consumer community stakeholders did not seem to know how to make use of these tools.

While Colorado expects quality to improve under its SIM Initiative, providers and other stakeholders interviewed noted that quality improvement initiatives take significant time and effort. Existing quality improvement efforts, such as those required by the National Committee for Quality Assurance medical home certification process, add to provider burden. For example, one PCP said that she had to work multiple, extra hours a week to send patients letters and booklets for check-up reminders and service referrals and would love to have a care coordinator manage these tasks.

Lastly, despite not being mentioned by providers and consumers, the state and participating payers will be monitoring, on a quarterly basis, primary care practices participating in physical health/behavioral health integration, on a set of 15 clinical quality measures chosen to align with existing initiatives under way in Colorado.¹¹ These core measures include three (flu, asthma, and obesity) to be reported by all practices, three (pediatric depression screening, maternal depression, and development screening) to be reported by pediatric practices only, and four (breast cancer screening, colorectal screening, adult depression screening, and substance use disorder and tobacco screening) to be reported by family or adult practices only. Additional clinical quality measures are optional, and will be rolled out in phases for practices willing to submit data directly to the QMRT data aggregation tool. Feedback on quality measure performance will be shared quarterly with practices. For details on the data collection and reporting tools as well as the current status of implementation, see *Section A.3.5*.

A.4.5 Population health

Colorado's main mechanism to improve population health under the SIM Initiative, as mentioned, is through integration of physical and behavioral health services. As such, broader population health strategies are designed to align with and impact traditional clinical strategies.

Currently, stakeholders' diverse understanding of population health in Colorado centers on the emerging trend of population health management and the role of public health agencies. From state officials' perspective, success in the SIM Initiative, with respect to behavioral health and broader population health, means establishing community linkages and a system supportive of mental health. Performance and outcome will be measured in two ways: (1) through population health outcomes mapped directly onto clinical health outcomes collected from participating practices, and (2) by looking at saturation of SIM activities around population health. Proposed population health measures to be pulled from claims data or reported by Cohort 1 practices include hypertension, obesity, prevention, asthma, diabetes, safety, depression,

¹¹ These existing initiatives are Colorado's Winnable Battles, U.S. Preventive Services Task Force A & B Recommendations, and CPCi measures.

anxiety, substance use, and child development. For the saturation measures, Colorado’s SIM Operational Plan, submitted in December 2015, proposed a list of progress indicators—including the number of providers that complete designated courses on behavioral health and substance use screening and the number of SIM-funded LPHAs collaborating in a coalition with community partners, among several others. However, one state official noted that population health is broad, and the Population Health Workgroup is in an ongoing process to define the detailed activities that will be rolled out over the next few years.

Overall, state officials anticipate small impact in population health over the next 2 years, partially because the need is huge and not a lot of funding is being allocated to population health work. Stakeholders outside state government raised concerns about the vagueness of the goals. In regard to specific SIM strategies around population health, providers and consumer advocates who know about the regional health connectors expressed concerns about sustainability of the program beyond the grant period, and about the efficacy of this new workforce in truly fostering community linkages between health care and broader population health strategies. Furthermore, although providers voiced a need for provider education around behavioral health issues, screening, and treatment, they were unaware of proposed SIM population health activities designed specifically to address this issue. The Population Health Workgroup and relevant agencies still need to better define the details of the SIM population health strategies, and these details will need to be clearly communicated to stakeholders across the state.

A.5 Overall Colorado Summary

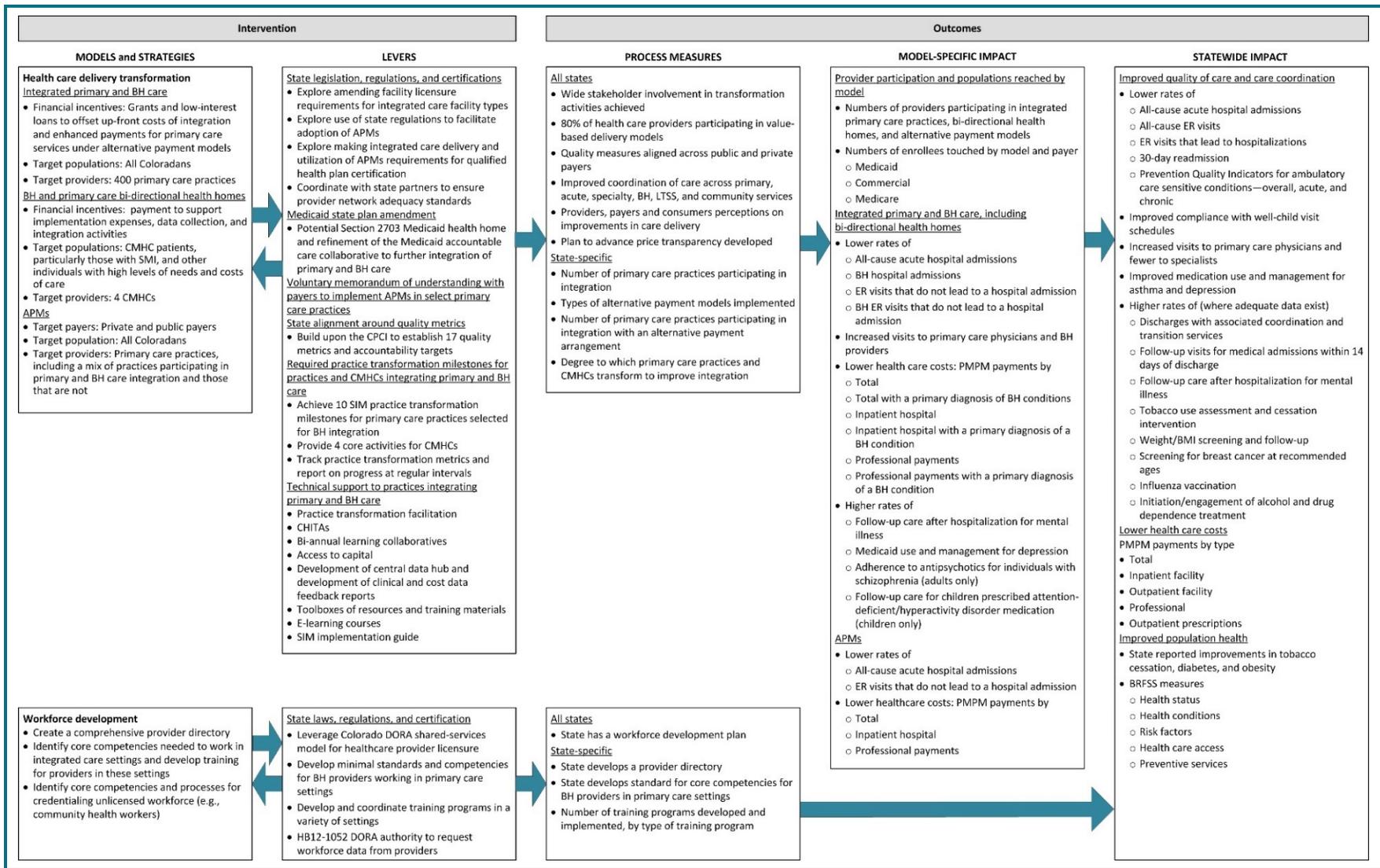
In the first 6 months of implementation, the first cohort of primary care practices was selected and connected with payers who will reimburse them with value-based payments, and four CMHCs were selected to begin integration with primary care. Roll-out of activities under population health and health IT also began. State officials, providers, advocates, and other stakeholders shared a pervasive sense of the excitement, energy, and possibilities for what Colorado can achieve through the SIM Initiative. The following will be watched closely by the RTI team over the coming year as part of the federal evaluation:

- ***Alignment of expectations between primary care practices and payers.*** Several types of stakeholders expressed concern that, if not treated carefully, the SIM Initiative may lose support of the primary care practices for this effort over the payment reforms accompanying practice transformation.
- ***Relationship between the primary care practices and their practice facilitators and CHITAs.*** This is to assess how practices are leveraging those relationships to move transformation forward.
- ***Roll-out of integration efforts in urban versus rural areas.*** This is to identify any barriers to integration in a rural setting and approaches to addressing them, which will provide key lessons learned for future cohorts of primary care practices.

- ***Communication of the vision and action plan for the population health strategies to stakeholders across the state by the Population Health Workgroup and the agencies charged with implementing these strategies.*** Based on site visit interviewees, the population health strategies of the SIM Initiative do not appear well understood.
- ***Operationalizing the vision of the QMRT+ platform.*** The work of the Health Information Technology and Data work group and Office of eHealth Innovation is critical to realizing a viable data aggregation and reporting solution.

Although the steps forward are significant, nearly everyone interviewed expressed the view that Colorado was incredibly well positioned for success—given the state’s history of participating in other federally funded transformation activities and its prevailing culture to experiment with health system change.

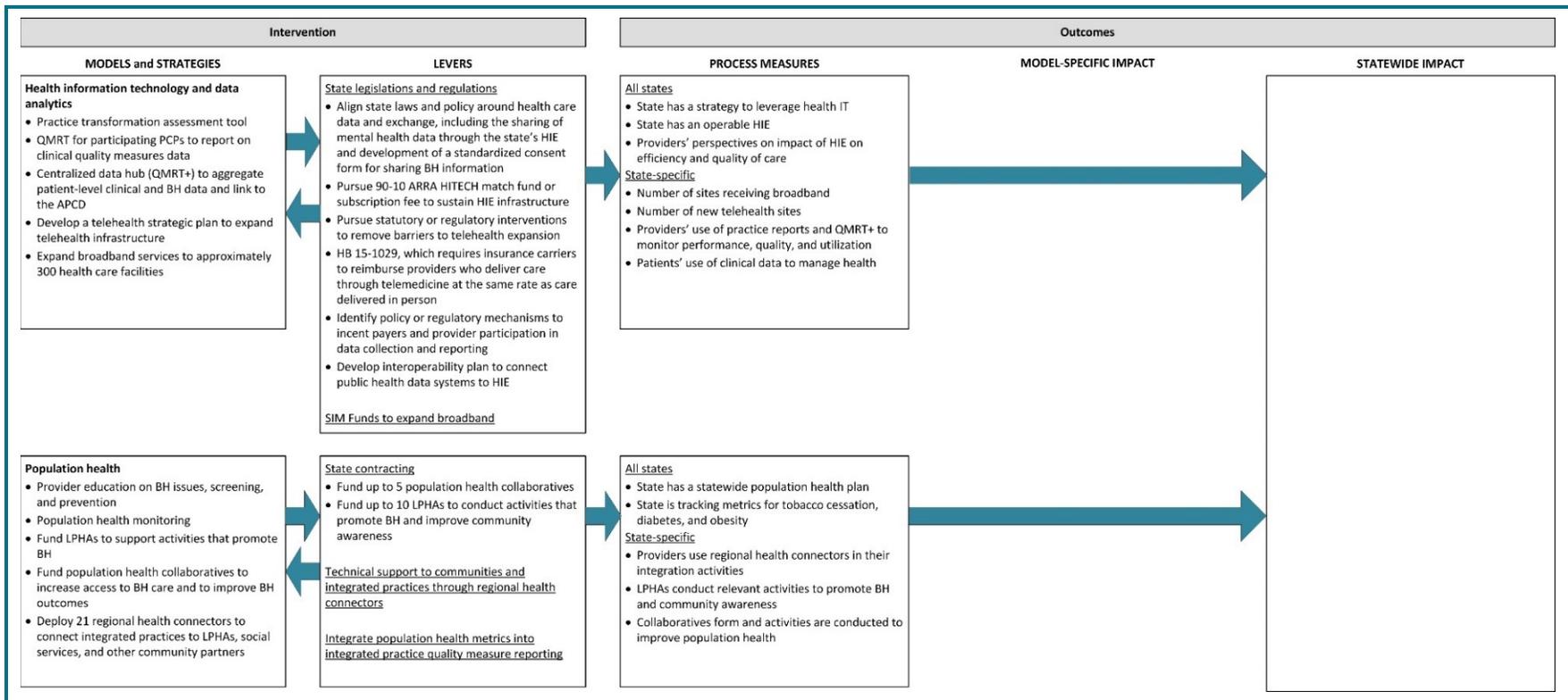
Figure A-1. Logic model for Colorado’s State Innovation Model activities



A-24

(continued)

Figure A-1. Logic model for Colorado’s State Innovation Model activities (continued)



A-25

APCD = all-payer claims database; APM = alternative payment model; ARRA = American Recovery and Reinvestment Act of 2009; BH = behavioral health; BMI = body mass index; BRFSS = Behavioral Risk Factor Surveillance System; CHITA = clinical health IT advisor; CMHC = community mental health center; CPCi = Comprehensive Primary Care initiative; DORA = Department of Regulatory Agencies (Colorado); ER = emergency room; HB = House Bill; health IT = health information technology; HIE = health information exchange; HITECH = Health Information Technology for Economic and Clinical Health; LPHA = local public health agency; LTSS = long-term services and supports; PCP = primary care provider; PMPM = per member per month; QMRT = quality measures reporting tool; QMRT+ = quality measures reporting tool +; SIM = State Innovation Model; SMI = serious mental illness.

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Appendix B: Connecticut Site Visit Report

During the 2016 site visit, which took place from May 2 through May 4, the RTI team conducted 13 key informant interviews in the greater Hartford and greater New Haven areas of Connecticut. The team also conducted three telephone interviews after the site visit, for a total of 16 interviews. The purpose of the interviews was to learn about the context of the state's health care system and early SIM implementation successes, challenges, and lessons learned. Interview participants included state officials from several state agencies or departments, and representatives from payers and purchasers, consumer advocate organizations, and provider organizations involved in the development and implementation of Connecticut's SIM Initiative.

During the site visit, the RTI team also conducted two focus groups with consumers and two with providers—to learn about their experiences with the current health care system in the state, and their awareness, if any, of the SIM Initiative. In these focus groups, the team spoke with Medicaid beneficiaries and Federally Qualified Health Center (FQHC) providers in Hartford, and primary care providers (PCPs) involved in the state's pilot Advanced Medical Home (AMH) program in New Haven.

This appendix provides an updated overview of the Connecticut SIM Initiative; describes the current health care context in which the SIM Initiative is being implemented; summarizes major early implementation successes, challenges, and lessons learned; and discusses key findings from the site visit interviews and focus groups, organized by major topical area. This appendix includes findings based on qualitative data collected through June 30, 2016. Further details on the analytic approach are available in *Appendix L*. Information on the site visit interviewees for the state is in *Table L-1*, and information on the provider and consumer focus group participants for the state is in *Tables L-4* and *L-5*, respectively.

B.1 Overview of Connecticut's SIM Model

Connecticut's vision for the SIM Initiative is to establish a whole person-centered health care system that improves community health and eliminates health inequities; ensures superior access, quality, and care experience; empowers individuals to actively participate in their health and health care; and improves affordability by reducing health care costs. The state's approach to meeting this goal involves the following three targeted initiatives to transform the state health care system for the majority of the population:

- ***Person-Centered Medical Home Plus.*** Connecticut's Department of Social Services (DSS) will enter into upside-only, shared-savings arrangements with selected FQHCs and Advanced Networks (ANs)¹² to provide Enhanced Care Coordination Activities to an upward projection of 400,000 Medicaid beneficiaries by 2018. If Person-

¹² Connecticut defines Advanced Networks as a larger network of providers that have organized to take responsibility for providing better quality care and lowering the cost of care by entering into value-based payment (VBP) arrangements with Medicare and commercial health plans.

Centered Medical Home Plus (PCMH+) generates savings for the Medicaid program, participating entities that meet identified benchmarks on quality performance standards and measures of under-service will be eligible to participate in shared savings. Participating FQHCs will also receive monthly payments for Care Coordination Add-On Payment Activities the FQHC provides to PCMH+ members.

- ***Advanced Medical Home Program.*** Connecticut will recruit 300 primary care practices to participate in practice transformation efforts to achieve standards in patient-centered access, team-based care, population health management, care management and support, care coordination and transitions, as well as performance measurement and quality improvement. Participating practices will receive technical assistance (TA) and participate in learning collaboratives. The AMH program support will be offered first to practices not yet recognized as medical homes within ANs participating in PCMH+.
- ***Community and Clinical Integration Program.*** Connecticut will offer targeted TA to 13 ANs or FQHCs participating in PCMH+, to enhance organizational capabilities in comprehensive care management, health equity intervention, and behavioral health integration. Practices committed to meeting Community and Clinical Integration Program (CCIP) standards will be eligible to receive monetary transformation awards to support relevant activities.

Supporting these targeted initiatives are statewide interventions to engage a broad array of stakeholders through advisory work groups, align quality measures across payers, and develop health information technology (health IT) to enable data use to track and improve health care performance.

Simultaneously, the state will engage consumers by promoting value-based insurance designs that remove financial barriers to—or introduce rewards for—preventive care, medication adherence, chronic disease management, and high-quality provider selection. To achieve health inequity reduction, the state will also devise a Population Health Plan that combines innovations in clinical health care delivery, payment reform, and population health strategies to improve health through a community approach (as opposed to solely focusing on patient panels).

For a complete list of what the state perceives to be its main test models and enabling strategies, please reference ***Table B-1***. Details of these initiatives are discussed under relevant sections of this appendix.

Table B-1. Summary of Connecticut State Innovation Model models and strategies

Model/strategy	Description
Plan for improving population health	<ul style="list-style-type: none"> Establishes a proof of concept model for PSCs to offer evidence-based community preventive in affiliation with PCPs. Develops a comprehensive plan for HECs to foster coordination and accountability among community organizations, health care providers, schools, and other entities, to improve health and social determinants of health in geographic areas with the greatest disparities.
AMH program	<ul style="list-style-type: none"> Provides support to facilitate practice transformation toward NCQA and Planetree PCMH recognition.
CCIP	<ul style="list-style-type: none"> Provides TA to ANs and FQHCs to enhance capabilities in such areas as supporting individuals with complex needs, reducing health equity gaps, and integrating behavioral and oral health.
PCMH+	<ul style="list-style-type: none"> Improves health outcomes and care experience for Medicaid beneficiaries, by rewarding providers with shared savings for improving access, care coordination, health outcomes, and health equity. Includes upside risk only.
VBID	<ul style="list-style-type: none"> Incentivizes and empowers consumers to manage their health and health care.
Workforce development	<ul style="list-style-type: none"> Focuses on developing the CHW workforce and incorporating CHWs into primary care teams or preventive service provision.
Quality measurement alignment	<ul style="list-style-type: none"> Develops core quality measurement set. Develops common cross-payer measure of care experience tied to VBP. Develops common provider scorecard.
Health IT	<ul style="list-style-type: none"> Develops advanced payer and provider analytic capabilities. Standardizes approach to clinical information exchange. Develops technology to enable development and use of multi-payer core measure set and common provider scorecard. Implements policy that allows for enhanced use of APCD (e.g., provides detailed analytics at individual level).
Consumer engagement	<ul style="list-style-type: none"> Conducts consumer outreach and education through public meetings, focus groups, and listening tours.

AMH = Advanced Medical Home; AN = Advanced Network; APCD = all-payer claims database; CCIP = Community and Clinical Integration Program; CHW = community health worker; FQHC = Federally Qualified Health Center; health IT = health information technology; HEC = Health Enhancement Community; NCQA = National Committee for Quality Assurance; PCMH+ = Person-Centered Medical Home Plus; PCP = primary care provider; PSC = Prevention Service Center; TA = technical assistance; VBID = value-based insurance design; VBP = value-based payment.

B.2 Logic Model

Figure B-1, located at the end of this appendix, is a logic model of Connecticut’s SIM Initiative depicting the hypothesized relationship between Connecticut’s SIM activities and improved care coordination, lower health care costs, and improved population health. Column 1 describes the key delivery system and payment reforms (AMH, CCIP, and PCMH+); and the enabling strategies in VBID, workforce development, health IT, and population health that are

expected to complement delivery system transformation. Column 2 shows the policy levers by which Connecticut will implement its strategies (e.g., state legislation and regulations, quality metrics alignment, TA, state financing).

As shown in Column 3, these activities are expected to lead to provider alignment with national models for shared savings and medical homes; providers and payers using clinical and cost data to improve management of individuals with complex needs; and more patients in value-based payment (VBP) arrangements, in addition to consumers feeling empowered to engage in illness self-management as well as make healthier lifestyle decisions. Column 4 shows that as the programs are implemented, participants are expected to increase their utilization of nonemergent care and state-selected quality metrics will improve. As shown in Column 5, these changes are expected to lead to statewide improvements in quality of care and care coordination, reduce per capita expenditures, and improve population health outcomes.

B.3 Implementation Activities

This section discusses current health care system/issues in the state, its SIM activities, and the existing infrastructure that will work with or alongside the SIM Initiative.

B.3.1 Context of health care system

The Connecticut SIM Initiative is best understood in the context of the state's health care landscape. Stakeholders in Connecticut reflected on numerous strengths of the state's health care system, and how this has positioned the state to adopt health care transformation. State officials and consumer advocates agreed that the Connecticut Medicaid program is currently regarded as an overall success in how it serves beneficiaries, and that it will provide a strong foundation for many SIM activities. Some stakeholders shared that particularly successful elements of the Medicaid plan include its comprehensive physical, oral, and mental health benefits. Several consumers and state officials commented that Medicaid beneficiaries in Connecticut have greater access to an array of primary care, dental, and behavioral health providers in comparison to other Medicaid programs.

Stakeholders also commented on the success of Medicaid initiatives—including the Person-Centered Medical Home program, which will serve as the basis for several key health care reforms under the SIM Initiative (including the AMH program and PCMH+). In addition to programs administered by the Medicaid agency, stakeholders felt the Health Enhancement Program—a value-based insurance program that offers reduced monthly premiums and lower cost-sharing for state employees who commit to receive certain preventive care—will serve as an important building block for the multi-payer VBID program under the SIM Initiative.

Beyond the health care transformation initiatives led by state agencies, stakeholders pointed to innovations led by private payers in the commercial market as major strengths of the Connecticut health care system, on which the SIM Initiative will be able to build. Connecticut

has a large and dynamic market of private payers, with 33 carriers insuring Connecticut's residents across the state.¹³ Major private insurers include Anthem BlueCross BlueShield of Connecticut and United Healthcare, both of which administer plans for state employees. Several state officials noted the emergence of commercial and Medicare accountable care organizations (ACOs) influenced the state's decision to pursue PCMH+ for the state's ACO-like ANs. Furthermore, Connecticut identified Anthem BlueCross BlueShield of Connecticut as a commercial payer that has significant reach in the state and is building a model for shared savings that aligns with Connecticut's SIM Initiative.

While stakeholders acknowledged the many strengths of Connecticut's health care system, stakeholders also described aspects with significant room for improvement. Many stakeholders cited Connecticut's stark health disparities and lack of statewide health IT infrastructure as priority issues for the state to address through the SIM Initiative.

A number of state officials and consumers referenced challenges in the state's current and previous Medicaid payment systems that have greatly influenced SIM payment reforms. The Connecticut Medicaid program, HUSKY Health, became a fee-for-service (FFS) system in 2012 after 15 years as a capitated managed care program. The prior managed care model is largely viewed as unsuccessful due to significant lack of cost transparency and under-service challenges. In the current managed FFS system, the state carries the financial risk and reimburses doctors and hospitals directly, using a nonprofit Administrative Services Organization (ASO) to process claims. Through PCMH+, the state plans to incorporate a shared savings program into the current managed FFS system. While many stakeholders were optimistic about the PCMH+ program, many consumer advocates have been hesitant to fully embrace PCMH+ due to concerns that providers will be incentivized to limit services (as they perceived was the case under the previous managed care system). At the same time, most stakeholders, including consumer advocates, said they recognize that Connecticut's current FFS system is unsustainable, and they generally supported a transition from volume-based payment to VBP.

State officials shared that stakeholders have had mixed opinions regarding the state's readiness to adopt alternative payment methodologies. Initially, some stakeholders believed that, as a Medicaid FFS state, Connecticut was not as well positioned to implement alternative payment methodologies in comparison to other states building on payment models that have already begun transitioning away from the volume-driven FFS model (e.g., to capitated Medicaid managed care). However, state officials indicated the current FFS system could be a strength, given that less coordination and alignment will be required to accomplish statewide, multi-payer payment and delivery system reforms than there would be had the state also needed to bring multiple managed care organizations on board.

¹³ Connecticut Insurance & Financial Services. (2015, November). *2015 Connecticut insurance market brief: Navigating disruption in a global industry*. Retrieved from <http://www.pwc.com/us/en/insurance/publications/assets/pwc-2015-ct-insurance-market-forecast.pdf>.

Stakeholders generally agreed that, while all the strategies under Connecticut's SIM Initiative would be beneficial to the state, those strategies that build on existing programs and infrastructure, such as the AMH and VBID initiatives, are likely to be the most fruitful. Most stakeholders were optimistic about the AMH program, and agreed it could be an impactful and effective care delivery strategy that builds on the state's existing Medicaid Person-Centered Medical Home program. Stakeholders also pointed out that several prominent commercial payers in Connecticut are already encouraging and incentivizing practices to become recognized as person-centered medical homes. In addition to the AMH program, many stakeholders were optimistic about the VBID strategy, especially given the success of the state employee health program and several employers in adopting VBID strategies.

Provider interviewees added that while the objectives of the AMH program are admirable, there will likely be challenges in fully operationalizing the model at the practice level. Practices will need support to achieve the system and culture change needed to drive a value-based system, as opposed to one that rewards volume. Discussions in the provider focus groups supported these statements—where physicians and nurses specifically selected due to their practice's participation in AMH were unaware of, or did not understand, either the Person-Centered Medical Home model or the AMH program. Of equal importance, provider focus group participants also described challenges with key practice functions—such as team-based care, population health management, care management and care coordination, data sharing, performance measurement, and quality improvement—that will be necessary for practice transformation under a person-centered medical home-like or AMH model.

Many stakeholders noted that certain aspects of the SIM Initiative that could have a major impact will also be the most challenging to implement. All stakeholders considered health IT to be a critical SIM component but were unsure how successful it will be, given the lack of vision and existing health IT and health information exchange (HIE) infrastructure, limited progress, and numerous challenges faced to date, including data interoperability and political barriers to data transparency (see Health information technology and data infrastructure **Section B.3.5** for a detailed description). Many stakeholders believe communication about the state's plans for improving health IT has been insufficient and commented on the need for real time data exchange and a viable quality measurement system. Stakeholders reported that alignment on a statewide health IT strategy will be challenging, given that certain payers have already adopted advanced health IT systems that are unlikely to be replicable across the state.

Quality measurement alignment was another key strategy stakeholders described as important, yet challenging, to implement. Payers, providers, and state officials noted that differences in payer populations and health IT infrastructure across the state will make alignment around a core measure set difficult. However, stakeholders acknowledged the quality council has been thorough and inclusive in its process to establish common measures, and stakeholders generally seemed comfortable with the proposed measure set. Additionally, state officials

reported that, while PCMH+ is likely to have a significant impact on care delivery and payment reform, it may also be difficult to implement—given the large scale of the program and lingering resistance among stakeholders, especially consumer advocates, who fear the program will encourage providers to limit services to meet quality measures. To address this resistance, the state delayed the launch of PCMH+ by 1 year (from January 1, 2016 to January 1, 2017) to enable collection and incorporation of additional consumer feedback and to foster greater consumer support (see the *Stakeholder Participation, Section B.3.3*).

A final and important piece of the health care transformation context in Connecticut is the state’s structural budget deficit. Nearly all state officials and most other stakeholders alluded to the deficit as a major obstacle that has affected the state’s ability to hire for SIM positions, due to a hiring freeze and layoffs for state employees. While agencies have found ways to contract for SIM positions, state officials reported that having to contract positions out, as opposed to hiring internal state employees, has significantly slowed the hiring process and led to a loss of momentum. State officials also noted general difficulties in recruiting candidates in the current climate due to concerns about job security and hesitance from applicants to accept temporary, grant-funded positions.

One state official also raised concerns regarding Medicaid’s capacity to participate in certain aspects of the SIM Initiative, given the significant impact the budget deficit will have on Medicaid’s resources and its ability to administer programs that predate the SIM Initiative and are not eligible for SIM funding. For example, the budget deficit may have serious implications for health facilities that receive state funding and the SIM Initiative will not compensate for this funding loss. Some stakeholders were concerned Medicaid will not be able to commit to all the new, time intensive SIM Initiatives while needing to focus on sustaining existing services with significantly less funding available. However, others seemed confident that Medicaid will move forward with PCMH+ in spite of the state budget challenges, because of its potential to improve care for Medicaid beneficiaries through its emphasis on care coordination and behavioral health integration. One state official commented on Medicaid’s commitment to PCMH+ and noted the state will need to implement PCMH+ cautiously, and be sure to “preserve care coordination payments under PCMH+ as the state faces an enormous structural budget deficit.” Another state official suggested the state needs “to use budget problems as an opportunity to align our thinking and be more efficient.”

B.3.2 Governance and program administration

The Project Management Office (PMO), located within the Office of the Healthcare Advocate (OHA), is responsible for the day-to-day operational aspects of the SIM Initiative. The PMO reports to the Lieutenant Governor, who is not directly responsible for day-to-day tasks but plays an integral oversight role and co-chairs the SIM Steering Committee with the State

Healthcare Advocate.¹⁴ State officials shared several advantages of having the SIM PMO housed in the OHA. OHA is viewed as a neutral, independent, and flexible agency that bears an equal relationship to the line agencies in the state—such as DSS, Department of Public Health, and Department of Mental Health and Addiction Services. One state official commented that placing the PMO in OHA was also an opportunity to bring more advocates on board and encourage them to embrace change.

State officials also pointed out several challenges the PMO has encountered in capacity and resources. State officials expressed the difficulties in accomplishing certain tasks from OHA, given the agency's limited administrative capacity. Prior to the SIM Initiative, OHA had insufficient experience with the contracting or procurement process, a major necessity for the SIM Initiative. As a result, the PMO is building all new administrative processes, and anticipates challenges in building the capacity to administer certain aspects of the SIM Initiative, such as transformation grants. State officials noted limited PMO staff resources will become increasingly challenging as the state transitions from design to implementation of SIM activities. State officials commented specifically on the need to hire for several additional positions to oversee financial management and quality measurement alignment, which may prove challenging given the difficulty of hiring state employees in the current environment.

Committees and work groups play an important role in guiding and operationalizing the Connecticut SIM Initiative. Stakeholders shared that the work groups provide (1) an opportunity for a diverse array of stakeholders (including state officials, payers, providers, employers, and consumers) to voice their opinions and concerns over specific elements of the plan and (2) input and guidance to the state. As of May 2016, the following committees and work groups have been created to specifically support and advise the SIM Initiative: Healthcare Innovation Steering Committee, Community Health Worker (CHW) Advisory Committee, Equity and Access Council, Population Health Council, Practice Transformation Task Force, Quality Council, Value-Based Insurance Design Consortium, and the Consumer Advisory Board (CAB). The Care Management Committee of the Council on Medical Assistance Program Oversight (referred to as the Medical Assistance Program Oversight Council [MAPOC]), which was created prior to the SIM Initiative to advise DSS on the Medicaid program, also provides input on the development of the PCMH+ program under the SIM Initiative. Although the state had launched a Health Information Technology Council to advise on health IT-related issues, the state disbanded the council per legislation passed in June 2016 that reorganized and streamlined health IT governance.

While stakeholders acknowledged the value of work groups, they raised concerns about the efficiency of the work group process. Most stakeholders were generally pleased with the

¹⁴ The State Healthcare Advocate oversees OHA activities in health plan selection, consumer health care rights education, consumer assistance with grievances and appeals, health care marketplace monitoring, and health care policy activities.

selection process for work group members and impressed with the diverse stakeholder representation on each committee. Stakeholders also agreed the groups present opportunities to share their opinions and become involved in the SIM Initiative, and said the state has been very receptive of their feedback. However, some stakeholders felt there were almost too many people engaged to be able to move the work groups forward at a reasonable and productive pace. According to stakeholders, the work group processes are often lengthy and not as efficient as they could be. One stakeholder described the number and length of meetings as “overwhelming,” and shared concerns over potential burnout of work group members. State officials shared similar concerns over work group efficiency; they also reported some confusion over the role of the work groups, but commented that they see the work groups as advisory bodies, not decision-making authorities.

Despite these challenges, several stakeholders shared that work groups usually produce a product (e.g., quality measures) that most members are comfortable with, and some work groups are able to reach consensus on a decision without needing to vote.

B.3.3 Stakeholder participation

Many stakeholders reported being very pleased with the level of multisector stakeholder inclusion, engagement, and participation in the SIM Initiative. Providers, consumers, and commercial payers and purchasers were satisfied with the public availability of SIM materials; and all reported feeling the state was very receptive to their feedback and incorporated their suggestions as much as possible. State officials described their extensive efforts to be inclusive and develop a robust governance structure that maximizes diverse stakeholder engagement, which is reflected in the composition of all work groups and committees—as well as in public meetings, targeted listening forums, and private meetings set up with the PMO.

From the state perspective, the most important stakeholders vary by SIM activity. For example, employer participation is crucial to the VBID project, and payers are key stakeholders for the quality measurement alignment initiative. State officials also reported that providers have contributed an essential perspective to SIM’s design and implementation. Many stakeholders commented on the major role consumers and consumer advocates have played in the design and implementation of the SIM Initiative. Consumers are represented in all committees and have been active participants, especially in Medicaid quality and payment reform initiatives. Both consumer advocates and state officials commented on the impressive degree to which consumers have organized themselves to prepare for meetings and unite their voice.

The state recruits stakeholders to participate in development and implementation of the SIM Initiative through public solicitations posted on the Connecticut SIM website and in the state’s SIM newsletter. Workgroup members are selected to participate through a competitive application process. The CAB—which takes the lead in reviewing and scoring applications and selecting work group members—comprises a combination of newly recruited consumers and

consumer advocates, in addition to members from a previously existing consumer advisory group housed in the former Office of Health Reform and Innovation.

Beyond work groups and committees, the state engages and educates stakeholders on health care transformation efforts through public meetings and symposiums hosted by the PMO, targeted public listening forums hosted by the CAB, and ad-hoc meetings and presentations arranged through the PMO. Examples of recent meetings include the “SIM Symposium: From Accountable Care to Accountable Communities,” the Southeast Asian Listening Session, and the Rural Healthcare Forum. Through engagement on committees and work groups, stakeholders have been key SIM partners. While a variety of stakeholders felt the state has been successful in ensuring diverse multisector stakeholder participation, state officials did report a few challenges that have come with meaningfully engaging and addressing the concerns of certain stakeholder groups. For example, the state has successfully engaged many of the larger provider groups and networks, but has not had as much buy-in on the SIM model from smaller, independent providers. These smaller, independent providers are concerned, according to state officials, that the SIM Initiative will be a heavy lift for their small practices and will accelerate provider consolidation.

Beyond providers, state officials described substantial resistance from Medicaid consumers and consumer advocates on PCMH+, due to fears that it will incentivize providers to limit services, given the state’s prior negative experience with Medicaid managed care. Stakeholders reported feeling that the current Medicaid program works well and does not require change. The state addressed many of these concerns by adjusting the structure of PCMH+ and delaying its launch by 1 year to enable collection and incorporation of additional consumer feedback and foster greater consumer support.

While the state initially considered a payment model with both upside and downside risk for providers, the state arrived at a model that only incorporates upside risk (i.e., shared savings) to lessen potential provider burden. State officials noted they saw opportunities to do additional community outreach and provide additional education to the public on the SIM Initiative before PCMH+ implementation begins in 2017.

B.3.4 Delivery systems and payment reforms

Connecticut plans to implement a number of complementary health care delivery and payment reform strategies to transform its health care system through the SIM Initiative. Given the state’s existing Medicaid Person-Centered Medical Home program and interest in continuing to advance primary care, Connecticut is implementing the AMH program to expand medical home transformation. The state has coupled the AMH program with the PCMH+ VBP strategy, to promote financial incentives that reward improved quality and reduced costs. CCIP is also directly linked to AMH and PCMH+, and will provide TA and support to entities participating in PCMH+—with a focus on improving comprehensive care management, health equity, and

behavioral health integration. The quality measure alignment initiative will support the state's VBP strategy by promoting multi-payer alignment around a core quality measure set for providers.

Beyond these care delivery and payment transformations, the state is implementing a VBID program that engages employers in incentivizing healthy lifestyles through insurance design. To spur community-level health improvement and disease prevention activities, the state will implement two complementary models under its population health plan: Prevention Service Centers (PSCs) and Health Enhancement Communities (HECs). While the state envisions HECs as a model for improving the health of communities with the greatest health needs, PSCs are seen as a tool that offers communities a portfolio of evidence-based interventions. To enable all these strategies, the state has also identified implementing advanced health IT, CHWs, and a consumer engagement plan as SIM priorities. *Table B-1* outlines and summarizes each of the state's care delivery and payment reform models and strategies.

State officials shared several significant changes made to the SIM health care delivery and payment models since Connecticut submitted its State Health Innovation Plan. For example, the PCMH+ VBP reform initiative intended to complement the AMH program was not finalized until after the SIM Design award, because Medicaid was not identified initially as a key SIM driver. Connecticut eventually chose to implement the PCMH+ model due to: (1) the state's recognition that Medicaid needed to be included in payment reform (as it covers about 20 percent of the state's population) and (2) the emergence of commercial and Medicare ACOs and corresponding shared savings plans that could serve as models.

Prior to the SIM Initiative, payers in Connecticut had already begun changing the way they reimbursed providers. State officials reported that PCMH+ was heavily influenced by implementation of Medicare and commercial ACOs' increasing adoption of shared savings plans. State officials said a considerable amount of market consolidation has been happening over the past 2 years in particular, and that an estimated 65 percent of PCPs are now affiliated with an ACO or ACO-like entity that participates in a commercial or Medicare shared savings plan. The state hopes, through the SIM Initiative, to achieve multi-payer alignment on a common VBP framework based on the Medicare ACO model.

Officials noted that the CCIP program also was added after the design phase, because the state saw a need to support enterprise-wide reforms (e.g., ANs, FQHCs) to complement practice-level reform occurring through the AMH program. Enterprise-wide capabilities were intended to address health equity gaps and improve outcomes and effectiveness of care by building linkages with community resources to manage care and develop clinical integration capabilities. State officials shared that they included two waves of the CCIP program to avoid overburdening providers.

As the state will be building on existing delivery and payment reform initiatives occurring around the state, state officials and payers generally felt comfortable with the payment reform efforts under the SIM Initiative, despite concerns raised by Medicaid consumers and advocates. One payer expected the AMH program to have the largest impact, given that many payers in the state are already encouraging practices to adopt Person-Centered Medical Home, and many providers are already engaged in an ACO in some way. A number of stakeholders agreed that both payers and the state are generally focused on moving forward in the same direction. However, one payer commented that, while most payers and purchasers of health care share common goals and overarching payment models, alignment around specific model components (e.g., quality measures) will be challenging.

B.3.5 Health information technology and data infrastructure

Stakeholders view the SIM Initiative as a catalyst and enabling mechanism for health IT, and health IT is considered an enabler of the payment and delivery system reforms. However, of all the components of Connecticut's SIM Initiative, stakeholders find the health IT component most problematic. There is consensus that Connecticut's health IT strategy is nascent in comparison to other states, and is the furthest behind of all the SIM elements. Issues range from lack of vision and expertise, to infrastructure, to communications challenges among key partners. The strategy is described as disjointed, and not as collaborative as it should be.

Stakeholders also said there is no clear vision, strategy, or solutions articulated. One stakeholder noted the need for more time to get a solid footing around health IT-enabling technologies and to determine which would be the best solution to Connecticut's health IT deficits. For example, stakeholders need to better understand the advantages of an edge server¹⁵ approach as opposed to a repository or other mechanisms to aggregate data and enable examination of data across payers. Overall, most stakeholders understood the limitations of the state's current health IT infrastructure, but were not aware of what solutions the state was considering or the status of implementing them.

Stakeholders offered significant criticism of progress on health IT, pointing to challenges related to management and organization of the health IT council—in which meetings have been cancelled, agendas are unclear, and presentations have been very technical and difficult to comprehend. Stakeholders articulated a lack of confidence in state government and in DSS, which has been leading the health IT component. One stakeholder also noted that health IT consultants were operating in the midst of a tense relationship among state partners.

Stakeholders did express optimism, based on legislation enacted at the end of the 2016 legislative session, to create a state health IT officer and move oversight from DSS to the

¹⁵ An edge server, in the context of health IT, is any server that resides on the edge between two networks (e.g., between different health plans, or between health plans and the state) that enables health plan data sharing and management.

Lieutenant Governor. This transition may help align what stakeholders describe as a disjointed health IT strategy. The Lieutenant Governor chairs the meetings for AccessHealthCT (the state's quasi-public health insurance exchange) which also houses the all-payer claims database (APCD). The Lieutenant Governor also leads the Healthcare Cabinet and the Healthcare Innovation Steering Committee, which serves as the advisory body for SIM.

In terms of infrastructure, the state does not have an HIE for data sharing, and there is a lack of clarity related to integrating the developing APCD and any new health IT or HIE strategies that may emerge. Although the APCD is legislatively authorized but not yet functional, under the direction of AccessHealthCT the APCD is making some progress. By the beginning of third quarter 2016, it is expected to have data for a significant portion of the commercially insured population, and Medicare data integration is expected sometime in August 2016. The APCD does not have a firm timeline for receiving Medicaid data, however, and there is confusion and uncertainty among stakeholders about whether Medicaid will be integrated, and about the scope of the APCD's role in broader data sharing strategies. In addition to claims data, one stakeholder expressed interest in integrating clinical data into the APCD. One limitation of the APCD is that its authorizing legislation only allows distribution of de-identified data. The APCD will produce reports mostly related to the quality and cost of procedures across the state, which may post preliminary reports by fall 2016.

The SIM effort for health IT has one component focused on quality measure production using edge server technology. The SIM Initiative is making progress on developing a final quality measure set with a multi-stakeholder group, and one stakeholder expressed optimism that when that process is complete, the health IT strategy will be in a better place to develop a timeline. One goal is to make the production of quality measures based on clinical data more efficient. Other strategies are related to information exchange to coordinate care and reduce waste. Another set of strategies relates to direct messaging, a provider directory, and support for the limited exchange of health information.

One challenge for the health IT work stream is the participation of national employers with office locations in Connecticut. According to one purchaser, given Connecticut's current lack of integrated electronic health records (EHRs) and practice-level transformation, transition to VBPs will need to rely on employers providing employee information to supplement clinical data collected from providers. One concern is that national employers currently using some different data format must pay someone to design a file that meets state requirements for participation in the APCD, which may discourage buy-in. There are also concerns among stakeholders regarding the privacy of information: the state may be requesting identifiable information that not all employees would embrace.

Several stakeholders raised a related health IT challenge—the potential for creating redundancy in development of a statewide health IT solution that does not account for existing private sector solutions. Some private systems have sophisticated technology for their members,

as noted, and are developing their own solutions for their own covered lives. The biggest challenge will be finding one product, system, or vendor to offer a common solution to a problem that payers and ACOs have already solved. Some hospitals and hospital systems have tremendous resources available to them and multimillion dollar EHR systems. They have data warehouses and backup systems and HIEs that work among their own provider systems. Asking them to adopt a less developed system for the sake of alignment across systems is a major potential hurdle.

B.3.6 Workforce development

Stakeholders indicate that Connecticut’s SIM workforce strategies are intended to ensure the state workforce evolves to make the care delivery reforms successful. All planned SIM work groups in Connecticut are operational except for a work force work group. The CHW work group serves as the workforce advisory committee because the focus on CHWs is the only SIM workforce initiative. The University of Connecticut (UConn) Health Center, a subcontractor working with the state on the SIM Initiative, supports this committee and is developing strategies to integrate CHWs into healthcare teams.

Stakeholders expressed support for the potential use of CHWs to support care coordination for a variety of high need populations in Connecticut—including people with complex care needs, populations that do not speak English or have low literacy skills, state retirees, and individuals in need of addiction and behavioral health services. One stakeholder commented: “I’m very excited about the focus on racial/ethnic disparities and the use of CHWs for people with complex care needs. . . I think it could be a boom to populations that don’t speak English, are low literacy, or need help.” Stakeholders expressed hope that CHWs will be truly rooted in their communities and able to serve a translation function between providers and patients.

PCMH+ care coordination payments are in part intended to migrate services to community-based settings. The Medicaid program is actively examining how to use Medicaid authority to cover CHWs.

Individual work streams have not yet been integrated with one another, but one stakeholder expressed promise for integrating CHWs and Prevention Service Centers, to take advantage of the evidence base that exists for CHWs delivering preventive services.

B.3.7 Technical assistance and other support resources

Few stakeholders commented on the SIM program team or CMS contractors; however, comments they did provide were positive. Stakeholders who commented said they believe CMMI has been collaborative, supportive, and reasonably efficient. The SIM program team has asked important questions to test reasonableness of no-cost extensions. CMS has been balanced and reasonable with changes in project officers. Stakeholders also identified specific CMMI staff

who have been background supports as needed to ensure continuity and have been generous with their time in addressing a huge range of questions that emerged. Stakeholders note that the CMMI staff worked with the Connecticut SIM team to figure out how to complete phases and projects.

CMMI contractors and sources of TA have also been responsive. The Office of the National Coordinator of Information Technology is providing invaluable, high-level TA on health IT strategy. Connecticut also has found assistance from the Center for Health Care Strategies and the National Opinion Research Center (known as NORC) at the University of Chicago to be helpful. These contractors have been responsive and respectful of timelines and are very good about tracking cases. However, they do not dig deeply into a subject—in particular, they do not go beyond publicly available resources on websites. Connecticut also has explored resources from additional sources, such as the National Committee for Quality Assurance (NCQA) and the Yale School of Medicine’s Center for Outcomes Research and Evaluation.

B.3.8 Progress, challenges, and lessons

Stakeholders pointed to the broad and inclusive SIM stakeholder process that has resulted in buy-in for a solid complex Operational Plan. The PMO has successfully coordinated and communicated with key stakeholders. The large and complicated governance structure tries to get as many stakeholders involved and heard as possible. The SIM process has enabled cultivation of relationships and revealed voices for change that believe state government can make a positive contribution. The SIM process has also legitimized the effort and started a lot of people—providers, consumers, and employers—who were not talking to each other regularly before the SIM Initiative to talk to each other. A community of people deeply believe in what the SIM Initiative is doing, and will help move it along. Some providers have embraced reform and are stepping up to the plate.

Stakeholder buy-in was critical to addressing advocates’ concerns that PCMH+ would induce providers to deny care. Consumer advocates have been protective of Medicaid, as noted, because the program has shown great success with improving quality outcomes since the 2012 shift from managed care to FFS, and there is a sense of wanting to build on rather than erode it. It took time to build protective mechanisms into the program (e.g., eliminating downside risk) while recognizing the value of transformation. The SIM PMO also needed to be sensitive to the interplay between the Medicaid structure and MAPOC and new SIM work groups in clarifying advisory and decision-making roles. Developing a protocol for communication between the SIM work groups and MAPOC was very helpful to this process.

Finally, stakeholders reported that the SIM Initiative is launching on time (per the latest timeline), which many stakeholders consider a success. After many delays at the beginning, such

as no cost-extensions and the decision to delay the launch of PCMH+ by 1 year, SIM is finally moving into the implementation phase and appears to be on track.

Stakeholders noted that the upcoming challenges for the CT SIM Initiative will be to begin implementation and hit targets across programs. The SIM Initiative is multifaceted and ambitious, requiring many heterogeneous changes that require varied levers. Though the state has made an effort to align the numerous initiatives it is undertaking through the SIM Initiative, not all initiatives target the same populations and it remains to be determined how the simultaneous launch of multiple new initiatives will impact certain groups. For example, some practices may participate in both AMH and PCMH+, while some only participate in one. The quality measurement alignment work is intended to align measures for organizations in a VBP program, some of whom may also participate in PCMH+, CCIP, and AMH. One stakeholder noted that it is hard to figure out how all the pieces fit together, and aligning all the work streams is difficult. One stakeholder even indicated that if they could start over, it would be preferable to have fewer activities—doing three things well as opposed to six things less well.

One stakeholder acknowledged another challenge—keeping stakeholders engaged as delivery models change and evolve. As best practices emerge, it could prove challenging to continue to keep all stakeholders flexible to incorporate the latest evidence base.

Similarly, stakeholders expressed concerns about the continued introduction of new efforts that are implemented simultaneously with older efforts. One stakeholder commented that Connecticut's ACO design under the SIM Initiative was based on an old model from CMMI and felt the state was “living the limitations” of that model. In the meantime, new models such as Comprehensive Primary Care Plus have emerged, and it may seem to some as though Connecticut is launching “yesterday's model” in its SIM ACO strategy. As a result, there are concerns providers will opt out of participating in Connecticut's ACO model.

All the SIM activities will be occurring as the state faces an enormous structural budget deficit, as noted, with diminishing resources across departments. This will impact Medicaid directly, and there is concern among stakeholders about the Medicaid agency's capacity to effectively participate in new, time-intensive SIM Initiatives such as PCMH+, while needing to focus on sustaining existing services and programs that predate the SIM Initiative and are not eligible for SIM funding.

In terms of work stream progress, SIM stakeholders noted the most progress on quality measure alignment and the least progress on health IT. The state has made progress around quality measurement alignment across payers and developing a set of quality measures that multiple payers support. Health IT, as noted, appears to be the major challenge up. Stakeholders point out that there is neither a clear vision nor enough communication. Once the plan is formulated, health IT alignment will be challenging in a state that has not figured out any form of HIE. Several stakeholders mentioned challenges related to interoperability across multiple data

collection systems. Another health IT challenge is lack of transparent data due to legislative de-identification requirements. According to one stakeholder, the state has data capacity but faces political barriers. Other stakeholders pointed to the need for clinical quality data in addition to claims data with real time reporting. There are also uncertainties about the investment required to operationalize HIE and health IT systems (i.e., costs, potential return of investment, and timeline).

In addition, concerns remain about the ability to move a well-entrenched medical care culture—including moving providers away from the concept of volume as a driver of services, improving care consistency, and implementing shared savings. For instance, one stakeholder asked who will claim shared savings if physicians do not earn their share by improving access, care coordination, health outcomes, and health equity. According to that stakeholder, “self-insured employers think they own it, insurance companies think they own it, and some advocates believe it should go into a fund.” Stakeholders also cited concerns about addressing consistency in care across providers; the likelihood of demonstrating cost reductions by delivering better care and in more cost-effective ways; the ability to reduce readmissions, emergency service use, unnecessary medications, and testing; and addressing health needs of populations across all social economic strata.

State officials indicated that they believe the SIM cooperative agreement provides sufficient resources to administer the programs in the SIM Initiative, but that implementation is influenced by other confounding contextual factors. For instance, the state’s structural budget deficit has resulted in insufficient staffing due to a state hiring freeze and layoffs, which have led to unanticipated workload challenges. The state officials indicated that, for this reason, without federal support the SIM Initiative might not be happening.

B.4 Statewide Changes

This section discusses stakeholders’ perspectives regarding what elements of the SIM Initiative they expect to impact desired outcomes and what those impacts might be.

B.4.1 Health care expenditures

Many stakeholders pointed to the cost of health care in Connecticut as a central concern. At the state level, Connecticut’s growing budget deficit has risen to a projected \$980 million for the 2016–2017 fiscal year.¹⁶ Medicaid spending represents approximately nine percent of the state’s budget.¹⁷ Many state officials are eager to implement initiatives that will reduce the cost of Medicaid in Connecticut while providing enhanced care to beneficiaries.

¹⁶ WTNH.com. (2016, April 29). *New budget figures show that Connecticut deficit has grown*. Retrieved from <http://wtnh.com/2016/04/29/new-budget-figures-show-connecticut-deficit-has-grown/>.

¹⁷ Connecticut Office of the State Comptroller. (2016). *Dept. of Social Services 2016: \$7.24 billion broken down by program*. Retrieved from <http://opencheckbook.ct.gov/#!/year/2016/explore/0-/service/HUMAN+SERVICES/0-barChart/departments/Dept.+of+Social+Services/0-barChart/program>.

Although Connecticut is a small state, it still experiences regional variation in the cost of care. Many practices in Connecticut are organized into Physician Hospital Organizations and Independent Practice Associations, and there is increasing pressure for physicians to align with one of several regional hospitals. Payers and purchasers reported that Connecticut residents are hesitant to travel for care, even when incentivized to do so by knowledge of perceived quality or reduced costs. This decreases incentives for hospitals to compete with one another on quality and cost. The relative lack of competition across the state also leads to regional variation in the cost of care, a phenomenon several interviewees described.

The FFS payment model has long dominated the payment landscape in Connecticut, and continued to do so even after other states had migrated towards systems that favor more cost sharing. Under the current managed FFS system, Connecticut strives to reduce administrative costs while increasing the number of providers who accept Medicaid payments. The Connecticut Medicaid program, HUSKY Health, has been structured as a managed FFS system since 2012, after 15 years as a managed care model. In a managed FFS system, the state carries the financial risk and reimburses doctors and hospitals directly. However, claims are processed by the nonprofit ASO.

ACOs and person-centered medical homes are relatively new to Connecticut. Recent broad physician alignment with hospitals has led to widespread adoption of ACOs among PCPs. However, some interviewees noted that participating providers are not fully transforming their practices. One stakeholder described some existing person-centered medical homes as collections of practices that continue to operate independently but share medical records; they have not adopted other changes associated with these models that are designed to improve the quality of care. According to some interviewees, practices in these fragmented medical homes still are motivated by volume of care rather than quality. Providers who participated in the focus groups echoed this culture of prioritizing care volume to meet the financial needs of practices. Providers also said they feel burdened by the administrative requirements of the current system, and are unable to hire additional staff to manage the load due to insufficient reimbursement. Beyond the immediate impact on expenditures, this focus on volume may challenge the effectiveness of the SIM Initiative more generally.

Connecticut's expenditure goal for the SIM Initiative is a one percent to two percent reduction in the annual rate of health care growth in the state. Given the priority to reduce health care costs, the state has designed several SIM strategies with that end in mind. Many stakeholders view PCMH+ as the strategy most likely to impact the state's health care spending. PCMH+ was designed to improve health outcomes for Medicaid beneficiaries and reduce costs. The state has been planning PCMH+ very cautiously, as noted, and has applied for no-cost extensions to its SIM award to ensure sufficient time to execute PCMH+ effectively.

Even if PCMH+ is implemented with fidelity to Connecticut's plan, however, the upside-only nature of the model means the state continues to carry the risk for medical spending. The

upside-only nature of the Medicaid shared-savings model was incorporated to alleviate some of the concerns from stakeholders that a downside-risk model may incentivize providers to limit the care they provide to Medicaid beneficiaries. Stakeholders noted concern that a downside-risk model could expose Medicaid providers to financial losses that could subsequently limit access to, and quality of, care for beneficiaries.

Other SIM Initiatives may impact expenditures across payers and purchasers. While the VBID design is still being developed, stakeholders described a vision where value-based insurance can be used both to improve health outcomes and reduce spending—by incentivizing beneficiaries to seek preventive services and manage chronic conditions, while discouraging overuse of certain services. Interviewees generally were confident in the ability of the VBID consortium to develop sensible and useful prototypes. However, they noted that the major challenge will be to increase employer uptake of VBID plans, particularly for national and international corporations operating in the state.

Several stakeholders thought the AMH program likely will reduce expenditures, as the enhanced management of care by the medical home will decrease the use of expensive emergency room (ER) visits and unnecessary specialty services. However, in the focus groups of providers from practices enrolled in the state-funded Vanguard AMH program (the Person-Centered Medical Home pilot from which the SIM AMH model is building), many PCPs said they have insufficient resources to operationalize such care. For the AMH program to realize cost savings, PCPs in Connecticut need to evolve how they operate their practices, a change providers in the state seem particularly hesitant to make.

Overall, while interviewees expressed doubt about whether the SIM Initiative alone will have a notable impact on the state's budget crisis, some were optimistic that these three programs (PCMH+, AMH, and CCIP) may reduce health care expenditures in Connecticut. But others thought the state's challenges with its budget, and opposing voices in the advocate community, may not allow implementation of the SIM Initiative to an extent that reaches its desired goal regarding health care expenditures.

B.4.2 Health care utilization

Utilization patterns among Medicaid beneficiaries in Connecticut had been changing prior to the SIM Initiative. Interviewees reported that the ASO has been making an effort to reach populations that typically are considered difficult to reach, providing those beneficiaries with more access to preventive care. Others reported that more PCPs and behavioral health providers may be willing to see Medicaid beneficiaries under the current managed FFS system. However, consumer focus group participants highlighted that Medicaid beneficiaries still have major barriers to preventive and specialty care, because of stigma and low reimbursement rates. Beneficiaries reported that they have struggled to receive basic services. Several beneficiaries related anecdotes of being unable to schedule appointments for primary care services, and either

struggling to get prescriptions for chronic conditions refilled or going to the ER to get these prescriptions. One notable exception to this is behavioral health care, which several interviewees said may be more accessible to Medicaid beneficiaries than to the general population in the state.

Prior to the SIM Initiative, the state had some efforts to shift health care utilization patterns. In addition to the Person-Centered Medical Home initiative, Connecticut has several Medicaid waivers that aim to shift patterns of utilization—such as the Connecticut Home Care for the Elders waiver, which provides in-home services to residents who may be at risk of nursing home placement.

Although none of the SIM Initiative’s major activities targets utilization directly, several related strategies, if successful, may impact utilization patterns. These strategies include VBID, which can improve health outcomes and decrease costs by providing beneficiaries with incentives to live healthy lifestyles and manage chronic conditions. VBID can encourage use of less expensive services while discouraging use of unnecessary services. As discussed in *Health Care Expenditures, Section B.4.1*, interviewees were optimistic that VBID can have its intended effects if the VBID consortium achieves buy-in from employers.

Two other Connecticut SIM strategies—CCIP and PSCs—also may influence utilization. CCIP, which targets populations with complex health needs, will provide TA to organizations participating in PCMH+ that will help them improve care management and integration—both of which could increase the use of preventive and behavioral health care. Similarly, the PSCs under Connecticut’s Plan for Improving Population Health, will increase access to preventive services. However, both CCIP and PSCs are in relatively early design stages and were rarely mentioned by stakeholders.

Few stakeholders identified improved utilization patterns (i.e., increased primary and preventive care and reduced high-cost acute, duplicative, and unnecessary care) as an important expected impact of the Connecticut SIM Initiative. Although interviewees identified problems with utilization in the state, they did not view the SIM Initiative as designed to target those problems. The components of the SIM Initiative that may impact utilization largely target the abilities of individuals to seek care, but do not address the structural challenges related to Connecticut’s regional focus. An ongoing challenge for the state will be improving the system-level challenges to changing utilization patterns—such as health systems that operate in siloes, inhibiting the communication necessary to implement change across the state.

B.4.3 Care coordination

The Connecticut SIM Initiative includes several strategies designed to improve care coordination. The AMH program does so most directly, and many stakeholders identified it as the program most likely to impact this area. As one stakeholder (an employer) noted, “the

promotion of AMHs will go a long way [in improving care coordination] ... it's a good start to work with primary care delivery, get people engaged with PCPs, get that care coordinated.”

Some stakeholders identified PCMH+ as another program that will impact care coordination, because it will build on DSS' existing Person-Centered Medical Home model by incorporating new Enhanced Care Coordination and Care Coordination Add-On Payment activities that participating FQHC providers will conduct. These activities entail integration of primary care and behavioral health care, building provider competencies to support Medicaid beneficiaries with complex medical conditions and disability needs, and promoting linkages to community supports that can assist beneficiaries use their Medicaid benefits.

In addition to the above add-on payments, state officials also noted the CCIP transformation grants will be distributed to help practices focus on improving care coordination (e.g., even more broadly between clinical and community care). A few stakeholders identified the CHW initiative as potentially facilitating patients' navigation of clinical and community care systems, and others expressed that VBID activities may potentially impact care coordination through incentivizing and empowering consumers to manage their health and health care.

Stakeholders confirmed improvement in the area of care coordination as necessary for better quality health care in the state, regardless of the SIM Initiative. Consumer focus group participants described the current situation as one where they are not able to identify many (if any) ways in which their care is being coordinated. Very few described being part of a care team, having care plans or care coordinators/managers, or discussing care goals with their providers. Many expressed frustration with their providers not knowing about or being up-to-date on their needs, medical history, or other services (sometimes as the result of frequent provider turnover). Consumer advocates echoed this concern. On the provider side, very few provider focus group participants acknowledged having a care coordinator or care manager on staff. Several described challenges they face when attempting to coordinate care, such as finding specialists for Medicaid patients and effectively sharing information.

In fact, one of the main challenges to effective care coordination identified by many stakeholders is the need for secure the sharing of patient data among all a given patient's providers. As discussed in *Health Information Technology, Section B.3.5*, this is an area of much needed improvement in the state. In the context of care coordination, stakeholders noted that patient data are “siloesd” and often not “real-time.” Stakeholders often described an environment where providers—practices, institutions, as well as public agencies—are on different health IT platforms that create interoperability challenges. Provider focus group participants described being overwhelmed with paperwork or electronic charting—which included receiving and having the time to process volumes of data from other providers, data that ideally would facilitate effective care coordination.

One area where progress towards improved care coordination has been made is in integrating behavioral and medical health care, some of which happened before or outside the SIM Initiative. Private nonprofit and public behavioral health providers, in particular, described efforts to integrate their behavioral care with medical care. Whereas one stakeholder described these efforts as happening in the past several decades, others described more recent approaches—for example, community-based behavioral health organizations establishing behavioral health homes, and state behavioral health agencies facilitating better access to primary care for behavioral health consumers. Still, challenges remain in this area. Behavioral health providers acknowledged persistent challenges around data sharing. Also, the interviews and focus groups provided little evidence of successful integration of behavioral health care into primary care. Finally, one state official noted room for improvement in behavioral and medical health care integration for commercially insured populations.

To address remaining challenges, additional efforts in the area of behavioral and medical health care integration have been taken during the early stages of the SIM Initiative. For example, one self-insured employer in the state described implementing pilot programs with providers, to increase care coordination for its employees with multiple chronic conditions. This stakeholder credited its involvement with the SIM Initiative as influencing that activity. In addition, SIM Initiatives such as PCMH+ and CCIP have specific elements designed to ensure behavioral and medical care integration.

Beyond integration or coordination of behavioral and medical health care, some stakeholders advocated that effective care coordination should—but does not yet or always—include consideration of a consumer’s social determinants of health, in addition to their medical and behavioral health. One stakeholder summarized what “success” would look like for care coordination under a framework of addressing social determinants of health as, “When we start to have a population in Connecticut with all of their needs met and not just physical needs, that’s when we’ll know we’ve succeeded.” Evidence that providers are considering the broader definition of health is beginning to emerge. For example, one provider noted that he and his practice colleagues are increasingly identifying and appropriately addressing all the needs of patients who are high service utilizers and have difficulty taking care of themselves, mainly for reasons related to nonmedical issues such as education, housing, and transportation. He explained, “Good health doesn’t happen inside the health system. Good health happens in society.” In addition, many of the integration efforts behavioral health providers are undertaking also accommodate social and supportive service needs.

Another key challenge to improving care coordination through the SIM Initiative, as identified by stakeholders, is identifying and funding individuals who could be responsible for care coordination. Stakeholders identified CHWs or nurses as individuals who might play this important role, but noted uncertainty about how these or any individuals would be supported. Some stakeholders expressed hope that care coordination would be “supported” through VBPs or shared-savings elements of some of the state’s SIM strategies (i.e., providers could be

“compensated” for care coordination through these arrangements versus through separate, additional fees). Finally, stakeholders were not yet sure how success in the area of care coordination can or will be measured.

B.4.4 Quality of care

Connecticut’s vision for the SIM Initiative, as noted earlier, is to establish a whole person–centered health care system that, among other outcomes, ensures superior access, quality, and care experience; and empowers individuals to actively participate in their health and health care. Although some stakeholders acknowledged positive aspects of these outcomes—for example, a few consumer focus group participants described positive relationships with their main providers—most stakeholders, particularly consumer and provider focus group participants, described several challenges. It will be important to monitor the impact that relevant SIM enabling strategies, such as the quality measure alignment and scorecard efforts (as well as its health delivery system and payment reforms such as AMH, PCMH+ and CCIP) may have towards improving on these challenges.

Many consumer focus group participants, for example, identified issues related to access and experience of care. A common “story” was one where a consumer could not get through to a provider’s office or clinic to make an appointment; was finally able to make an appointment but for a time far in the future; spent inordinate time in the provider’s waiting room before the appointment; was rushed through the appointment; and was given medications s/he did not necessarily want or need, as a simple and quick panacea. Several consumer focus group participants noted frequent turnover among their regular care providers, which created disruptions in provider-patient relationships and sometimes affected continuity of care. Several consumer focus group participants described disrespectful encounters with providers or their staff, where the consumers were insulted (e.g., told they are overweight), or treated as if they were ignorant (“they treat you like they don’t know you have education”), “crazy,” or “taking up [the provider’s or staff’s] time.”

Provider focus group participants expressed notable frustration with several factors that may be affecting the access issues consumers noted. Foremost among these challenges are the EHR issues noted elsewhere in this appendix. As one provider explained and others agreed, “We’re always stymied by [them]. It’s basically low level data entry by a highly trained professional. It slows you down. You can’t see more patients. It occupies your time. If you didn’t do it, you could see a bunch more people a day with a lot more face-to-face time. In order to go forward, you need to find a way to rid most of us of data entry ... It takes [a lot of] time to try to read and scan. Every day, reams and reams of paper. [It’s a] big problem for us to be efficient and provide high quality care.”

Provider focus group participants gave their own perspectives regarding access to and experience of care. Several private sector providers said they were hesitant to accept Medicaid patients, or did not historically serve them but are now starting to, and are facing challenges such

as difficulties finding specialists that will accept a Medicaid patient referral. Some providers also appear to have misunderstandings or stereotypes of Medicaid patients that confirm the consumer perspectives described above. For example, some private providers labeled Medicaid patients as unreliable (not showing for appointments) or inferred that they are unmotivated. But other public (FQHC) providers acknowledged the complexity that may be involved for a Medicaid patient to attend an appointment (stepping away from other obligations, finding and paying for accessible transportation, etc.), and showed more understanding and accommodation.

Within the context of these quality of care issues, the state has identified two SIM goals related to quality of care: (1) achieve top-quintile performance among all states for key measures of quality of care, and (2) increase the proportion of providers meeting quality scorecard targets. The two main efforts towards these ends are identification of a core set of measures for the assessment of primary care, specialty, and hospital provider performance; and development of a common provider scorecard format for all payers. As these efforts are still nascent, for the most part only stakeholders directly involved with them were aware of or able to describe them.

Stakeholders reported that the first and current process—identifying a core set of quality measures—has been long and arduous, albeit productive. The second process—developing a common scorecard—has not yet begun. The Quality Council began by reviewing all quality measures in use by any payer in Connecticut (one stakeholder identified the number as 150–200 measures); and systematically sought extensive input from providers, consumer advocates, and payers to align around a smaller set of measures. Each stakeholder group had different perspectives. As a state official aptly described, “Payers had concerns around aligning different measure sets in 50 different states, due to national profiles, as well as resources required to get the measures into contracts, etc. Consumers also had a very important role. They pushed equity and patient-centered measures. Providers pushed measures that were feasible and doable for providers at the point of care without being too taxing. State agencies were there to provide a more global perspective.” The Quality Council also sought expertise from NCQA and the Yale School of Medicine’s Center for Outcomes Research and Evaluation, and the PMO sought input from CMS on certain quality measures.

Although the process of seeking input from multiple stakeholders with different perspectives has been challenging, a few stakeholders identified this strategy as unique (i.e., not typically done) and one that may increase the likelihood that these efforts will be sustained (“no one entity can invoke changes that will be lasting”). Although some of the quality measure alignment work coincided (and still coincides) with similar work at the national level that could potentially be leveraged or could inform it, one stakeholder characterized this as “an alignment process for Connecticut [only],” indicating Connecticut may diverge from national models to meet its needs and priorities.

To better ensure successful buy-in and implementation of a core quality measure set, some stakeholders recommended that the goal or outcome of the alignment process be

simplified. For example, one payer advocated for “a model with a set of metrics with some flexibility in those metrics, that [entities] can and do choose from.” This stakeholder refined her suggestion as: “we [all] need... to be marching in the same direction to actually impact something. We will need to pick a short list of something to actually act on. A short list... [that is] actually driven by data. Pick a few areas and have some specific metrics focused on those areas. And then get some commitment and buy-in.”

B.4.5 Population health

Connecticut has two aims for improving population health. One is to reduce statewide rates of diabetes, obesity, and tobacco use. The other is to close the gap between the highest and lowest achieving populations on key quality measures. At the time of the 2016 site visit, a Population Health Council had just been established. Moving forward, the Council will begin introducing this area of work to stakeholders across the state. Over the 4-year grant period, the Council will be developing a plan for improving population health in the context of payment, insurance, and practice reforms as well as community integration and innovation.

The overarching framework for Connecticut’s proposed plan for improving population health reflects stakeholders’ diverse perspectives of current population health challenges and opportunities in the state. Focusing on their aggregate patient panel, large provider networks and commercial payers see an emerging trend for population health management. Along those lines, larger employers recognize a substantial opportunity to improve availability and access to community-based prevention services. On the other hand, state officials reported that, despite Connecticut’s high ranking on general health status measures compared to those of other New England states, stark disparities exist among subpopulations identified by race, ethnicity, geography, and income. To reduce these disparities, the broader public health community in the state has pushed for a necessary shift from traditional population health approaches to an explicit focus on subpopulations impacted by issues of health inequity, and the social and environmental determinants of those disparities.

To incorporate health equity in its health reform efforts under the SIM Initiative, Connecticut proposes to develop two primary population health-enabling structures: (1) PSCs and (2) HECs. By design, PSCs are community-based organizations that would provide evidence-informed, culturally and linguistically appropriate prevention services. At the time of the site visit, the state was in the very early stages of planning for PSCs. To implement population health strategies and interventions beyond the health care system, Connecticut is proposing to establish HECs, which are shared governance structures with multisector partners that can be held accountable for the health of the community at large. This model is designed to be implemented in communities with the highest risks for health disparities. Despite concerns over the financial sustainability of either model due to the state’s current budget deficit, state officials said they expect to develop, at a minimum, a proof of concept model for PSCs and a comprehensive plan for HECs by the end of the SIM award.

Stakeholders discussed the challenges of making improvements in population health given the role of social determinants beyond traditional health care (e.g., housing, employment, literacy). One stakeholder advised that the state would need to be creative in developing a solution for health inequity and leverage existing resources around the state, given the competing demands to improve health outcomes and other social determinants of health.

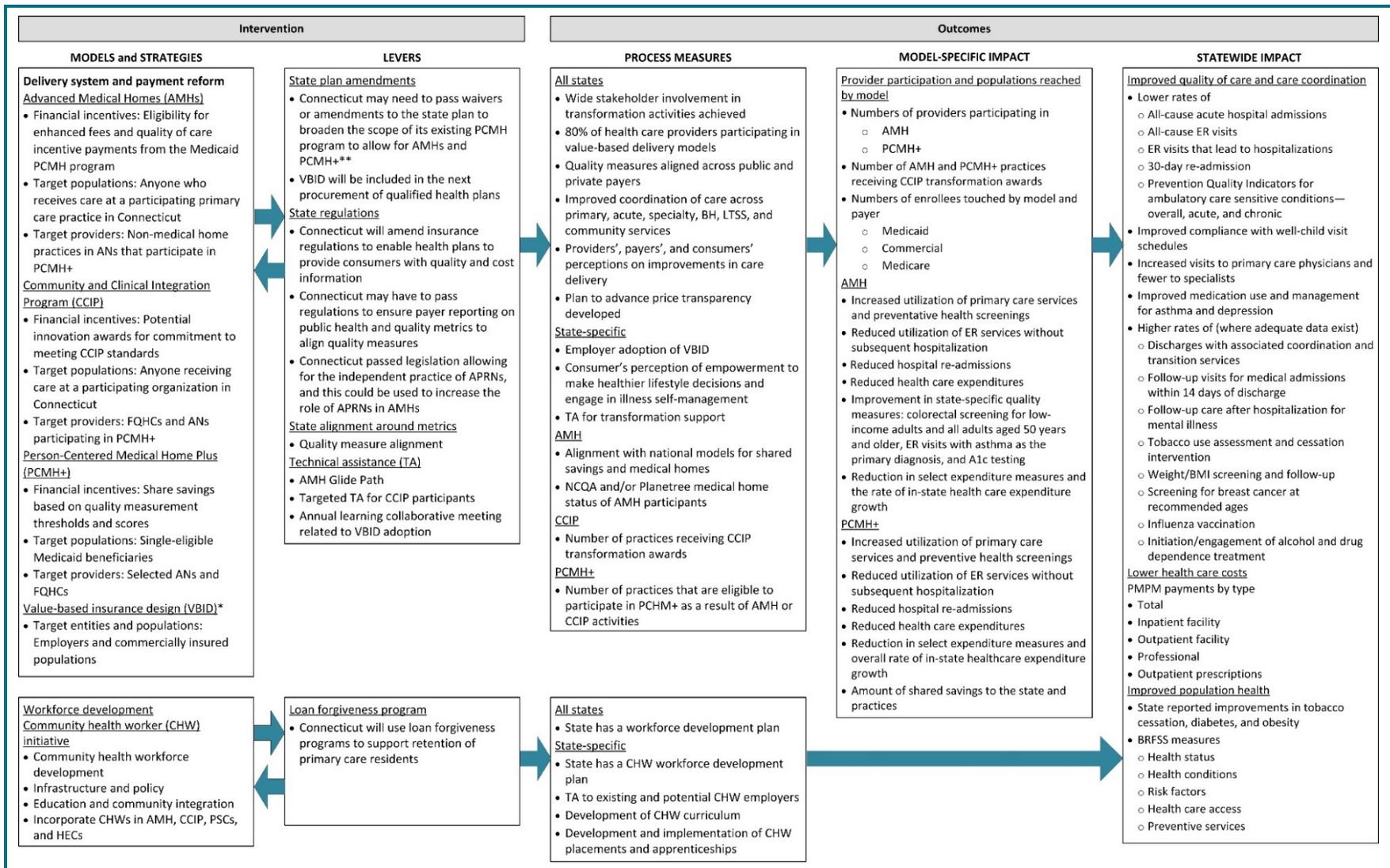
To measure progress, the state will monitor population health data throughout Award Years 2-4, via the Behavioral Risk Factor Surveillance System and other population health assessment processes separate from the SIM Initiative. Furthermore, state officials noted that raising the profile on issues of health inequity in the state will require examination of quality measures by race and ethnicity. According to the latest draft of the state's evolving SIM Operational Plan, 10 of the 33 core measures encompassing preventive care, acute and chronic care, and care coordination are prioritized for race and ethnic stratification. Payers will be encouraged to include those measures in VBP scorecards and factor health equity gap reductions into their calculations of provider payment rewards. At the time of the site visit, state evaluators at UConn Health were developing a state evaluation dashboard that would present summaries of this core set of measures by gender, race/ethnicity, income, and insurance payers as data allow.

B.5 Overall Connecticut Summary

The Connecticut SIM Initiative is a comprehensive strategy that addresses health care quality improvements as well as aims to reduce health care expenditures. Through iterative and ongoing processes of deliberation, consultation with experts, and stakeholder engagement, the state has designed major elements in the SIM Initiative and continuously refined them to address challenges and shortcomings in the current health care system. At the same time, targeted interventions leverage existing initiatives, such as the Medicaid Person-Centered Medical Home program, and build on successful aspects of the current system, such as the emerging focus on population health management.

During the 2016 site visit, stakeholders expressed cautious optimism about the SIM Initiative's ability to transform the state's health care system. With its most recent no-cost extension, Connecticut's Award Year 2 (September 28, 2016–September 27, 2017) had not yet begun at the time of that visit. Successful implementation in the coming year and future years of the test period will require increased buy-in and commitment from stakeholders; coordination and alignment of inter-related SIM activities, initiatives, and work streams; significant improvements in health IT; and noticeable shifts in longstanding health care culture and practices.

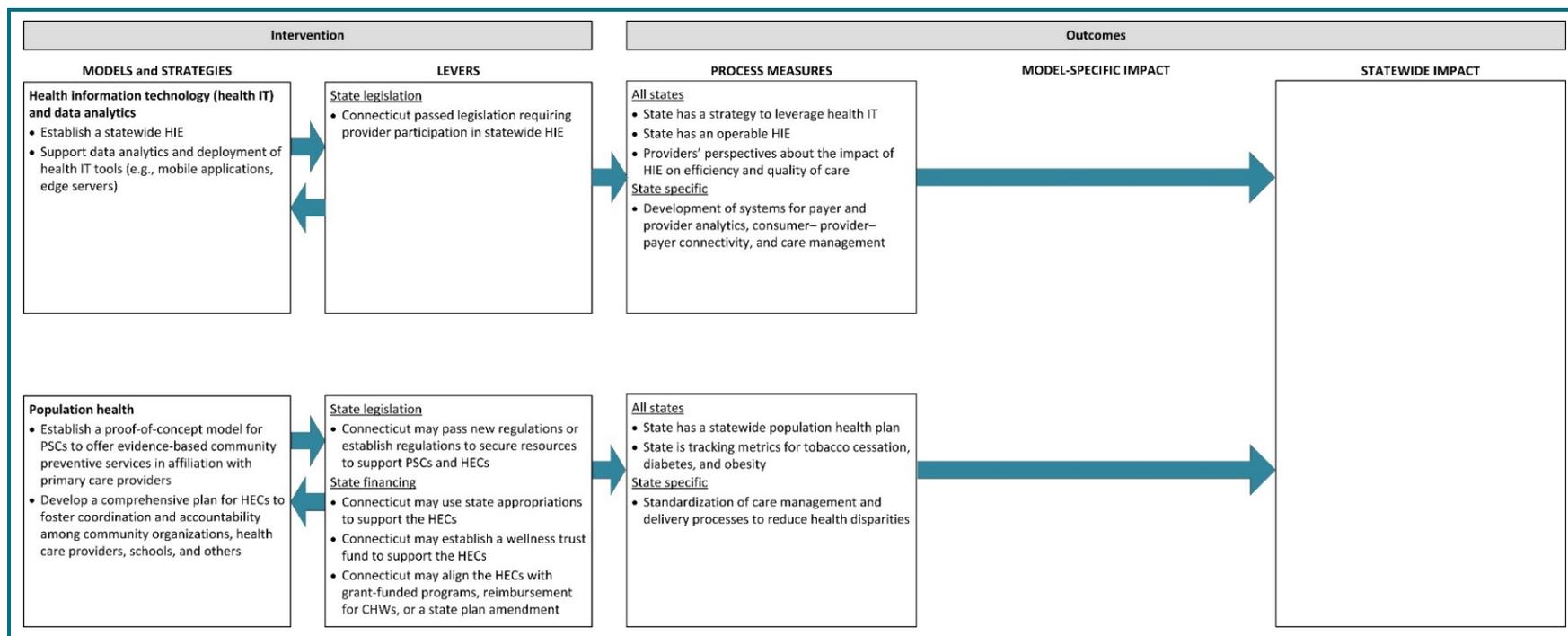
Figure B-1. Logic model for Connecticut’s State Innovation Model activities



B-27

(continued)

Figure B-1. Logic model for Connecticut’s State Innovation Model activities (continued)



B-28

*VBID is an enabling initiative designed to increase consumer demand for value-based health care.

** During the reporting period (February 1, 2015–June 30, 2016), PCMH+ was known as Medicaid Quality Improvement Shared Savings Program (MQISSP). The information regarding PCMH+ included in this report relate to program details and stakeholder understanding of MQISSP.

AMH = Advanced Medical Home; AN = Advanced Network; APRN = advanced practice registered nurse; BH = behavioral health; BMI = body mass index; BRFSS = Behavioral Risk Factor Surveillance System; CCIP = Community and Clinical Integration Program; CHW = community health worker; ER = emergency room; FQHC = Federally Qualified Health Center; health IT = health information technology; HEC = Health Enhancement Community; HIE = health information exchange; LTSS = long-term services and supports; NCQA = National Committee for Quality Assurance; PCMH = person-centered medical home; PCMH+ = Person Centered Medical Home Plus; PMPM = per member per month; PSC = Prevention Service Centers; SIM = State Innovation Model; TA = technical assistance; VBID = value-based insurance design.

Appendix C: Delaware Site Visit Report

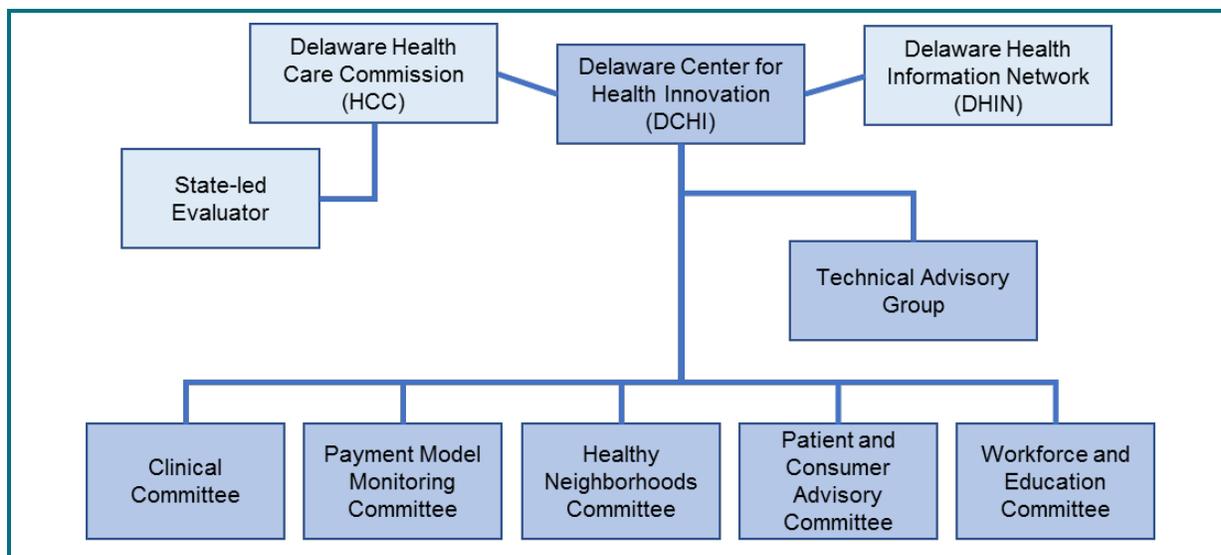
The 2016 site visit to Delaware took place from April 25 through April 27, 3 months into Delaware’s implementation of the SIM Initiative. The RTI team conducted 11 interviews on site and four interviews by phone after the visit, for a total of 15 interviews. Interview participants included state officials, payers, providers, and consumer advocates. The purpose of the interviews was to learn about the context of the state’s health care system and early SIM implementation successes, challenges, and lessons learned. The team conducted two provider focus groups with primary care practitioners in Wilmington. The team also conducted two consumer focus groups—one in Wilmington with Medicaid beneficiaries and one in Dover with state employees—to learn about the current health care system in the state and their awareness, in any, of the SIM Initiative.

This appendix provides an overview of the SIM Initiative; describes the current health care context in which it is being implemented; summarizes major early implementation successes, challenges, and lessons learned; and discusses key findings from the 2016 site visit interviews and focus groups organized by major topical area. This appendix includes findings based on qualitative data collected through June 30, 2016. Further details on the analytic approach are available in *Appendix L*. Information on the site visit interviewees for the state is in *Table L-1*, and information on the provider and consumer focus group participants for the state is in *Tables L-4* and *L-5*, respectively.

C.1 Overview of Delaware’s State Innovation Model

A central component of the Delaware SIM Initiative is creation of infrastructure to support the collaborative process during SIM implementation. This infrastructure consists of the Delaware Health Care Commission (HCC), the Delaware Center for Health Innovation (DCHI), and, the Delaware Health Information Network (DHIN). The Delaware HCC led creation of the SIM Operational Plan and continues in the SIM policy setting role. DCHI was formed as a nonprofit corporation to continue the regular and significant involvement of stakeholders in the implementation process. Specifically, DCHI is a member organization of DHIN—the state’s Health Information Exchange (HIE)—with DHIN the sole member of the DCHI organization. It is important to note that governance of the SIM Initiative in Delaware places DCHI in a central role, but continues to recognize the unique and necessary role of state government to set health care policy implementation. *Figure C-1* depicts the Delaware HCC and the DHIN, along with DCHI, as the combined leadership for the Delaware SIM Initiative.

Figure C-1. Delaware State Innovation Model Initiative governance structure¹⁸



The five DCHI committees shown—Clinical, Payment Model Monitoring, Healthy Neighborhoods, Patient and Consumer Advisory, and Workforce and Education—constitute one important way stakeholders remain engaged in the SIM implementation process.¹⁹ Delaware augments this formal committee structure with communication strategies embedded within action plans for specific initiatives, such as town hall meetings and provider outreach.

The Delaware SIM Initiative’s goal is to “improve on each dimension of the Triple Aim,²⁰ plus one: to improve the provider experience.” Additionally, Delaware hopes to be one of the five healthiest states, be among the top 10 percent of states in health care quality and patient experience, and bring the growth of health care costs in line with gross domestic product growth. To achieve this goal, Delaware uses seven major strategies to transform the health care delivery system:

- **Implement multi-payer, outcomes-based payment models.** Commercial payers are encouraged—and Medicaid, state employee benefit third party administrators, and Affordable Care Act (ACA)²¹ marketplace qualified health plans—are expected to offer both a total cost of care (TCC) model (shared savings) and a Pay for Value (P4V) model (bonus payments) to primary care providers (PCPs) or their affiliated accountable care organizations (ACOs), health systems, and networks. These

¹⁸ Delaware Center for Health Innovation. (2016, March). *State Innovation Model operational plan*. Retrieved February 7, 2017, from <http://www.dhss.delaware.gov/dhss/dhcc/files/simoperplanyear1.pdf>.

¹⁹ Ibid.

²⁰ Berwick, D. M., Nolan, T. W., & Whittington, J. (2008). The triple aim: Care, health, and cost. *Health Affairs*, 27(3), 759–769. doi: 10.1377/hlthaff.27.3.759

²¹ The Patient Protection and Affordable Care Act (P.L. 111-148) and the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).

payments are to incentivize and reward providers for achieving performance standards contained within the Common Scorecard, which is a set of 26 consensus-based quality measures (see **Section C.3.4**). The goal is that 90 percent of PCPs will participate in at least one TCC and one P4V model by 2018.

- ***Improve care coordination for high-risk adults and children through development of patient-centered medical homes, health homes, and accountable care organizations.*** The goal is to have each Delawarean assigned to a PCP, and to have at least 50 percent of the PCPs participating in practice transformation by the end of 2016. Further goals are to develop shared electronic tools for care coordination and a Web-based, multi-payer portal, and to enroll 75 percent of long-term care providers in Direct²² secure messaging through the DHIN.
- ***Utilize practice transformation facilitation as a critical tool to help primary care practices achieve the improved care coordination outcomes identified.*** Delaware is using SIM funding to pay four vendors to be available to help primary care practices complete the medical home readiness assessment and make the necessary changes to achieve patient-centered medical home (PCMH) status.²³
- ***Integrate primary care and behavioral health care.*** The state is including 50 behavioral health providers adopting electronic health records (EHRs) to facilitate care coordination.
- ***Engage patients in their health through access to their community health record—as well as health literacy, patient portal, advanced care planning, and other patient engagement tools.*** Delaware also intends to shift the focus toward individuals taking responsibility for their own prevention and chronic disease management.
- ***Implement a Healthy Neighborhoods initiative to improve population health in one or more of the following areas, to be chosen by the community:***
 - Healthy lifestyles
 - Maternal and child health
 - Mental health and addiction
 - Chronic disease prevention and management
- ***Ensure Delaware has the workforce capacity needed to deliver team-based integrated care for the entire population, through learning collaboratives and training on providing team-based care.*** Delaware also plans to develop a credentialing strategy to remove regulatory barriers to team-based care.

Delaware has developed a robust health information technology (health IT) roadmap as part of its SIM Initiative, to provide the critical information and technology infrastructure for successful implementation of the initiatives and evaluation of their impact. This roadmap

²² United States Department of Health and Human Services. (2014, July 15). *Interoperability portfolio (archive): DIRECT Project*. HealthIT.gov. Retrieved September 15, 2016, from <https://www.healthit.gov/policy-researchers-implementers/direct-project>.

²³ Delaware Center for Health Innovation. (2016, March). *State Innovation Model Operational Plan*. Retrieved February 7, 2017, from <http://www.dhss.delaware.gov/dhss/dhcc/files/simoperplanyear1.pdf>.

includes (1) continuing to work with providers to increase and improve the data being submitted to DHIN; (2) providing the technology infrastructure and user interface for operationalizing the Common Scorecard, which is a multi-payer provider performance measurement tool; and (3) developing an all-payer claims database (APCD).

C.2 Logic Model

Figure C-2, located at the end of this appendix, is a logic model of the Delaware SIM Initiative, depicting the hypothesized relationship between specific elements of the SIM Initiative and changes in outcomes. Column 1 describes the models and strategies that Delaware is pursuing with its SIM funds. Column 2 depicts specific policy levers that encourage or mandate participation in the SIM Initiative—including regulatory authority, Meaningful Use incentives, and grants to behavioral health for EHR adoption.

The remaining columns in the logic model identify the expected impacts of the SIM activities. Column 3 primarily identifies process measures CMS and the state hope to influence through Delaware’s SIM Initiative (e.g., getting 80 percent of health care providers to participate in value-based delivery models). Column 4 identifies specific outputs the state expects to achieve through the state’s core SIM activities—outcome-based payment models, care coordination, integration of primary and behavioral health care, patient engagement, and Healthy Neighborhoods. Column 5 identifies statewide impact measures that will assess whether Delaware has reached its SIM goals of improved quality of care and care coordination, lower health care costs, and improved population health.

C.3 Implementation Activities

C.3.1 Context of health care system

Documentation from the state indicates that the state’s delivery system is “both highly fragmented (for primary care practices, in particular) and highly concentrated (i.e., six hospitals and the Veterans Affairs hospital).” Delaware has three distinct geographic regions (north, central, and south) with different demographics, health experiences, and needs. Stakeholders characterized the Delaware health care system as disconnected and competitive, with disparities in access, utilization, and costs. One provider explained that each of the two health systems in the north, the two health systems in the south, and the health system in the central part of the state addresses the unique health needs within its community, but never in tandem across the state, leaving coverage gaps. Additionally, one provider explained that, prior to the SIM award, health systems built their own referral bases and expertise, and did not share their knowledge with the other health systems.

Access to care is also an issue in Delaware. Provider focus group participants identified lack of access to psychiatrists and other behavioral health professionals as a concern. Shortages of mental health providers are particularly acute in rural areas, which also needs more PCPs.

Provider focus group participants noted that it is particularly challenging to find behavioral health services for their pediatric patients that are covered by insurance. The state hopes to address the statewide shortage of mental health providers by integrating behavioral health and primary care services as part of the SIM Initiative.

Provider focus group participants also expressed frustrations with the current health care system, which focused on their relationship with payers in the state. Providers said they feel subject to excessive bureaucracy and regulations, and objected to the requirements for prior authorization from insurance companies. Providers explained that obtaining prior authorization alone could be a full-time job for a practice staff member, and this requirement has restricted or delayed their ability to prescribe effective and affordable medication for their patients. Many providers in the focus groups reported a general sense of having to do more work without having the resources to do it. In addition to the prior authorization issue, providers mentioned the paperwork required for reporting quality measures. They also noted an insurance regulation prohibiting providing care to patients in certain settings as a frustration. Providers explained that the changing health care landscape and regulations limit their ability to provide certain services they were once able to provide, such as home, hospital, or skilled nursing facility visits.

The 2016 site visit interviews made it clear that stakeholders view each component of the SIM Initiative as important and related. As one stakeholder described, the SIM models are “purposefully connected,” and all models must be implemented for the desired outcomes to be realized. Despite the concerns stakeholders expressed about the current health care system in the state, they were optimistic that the relatively small number of stakeholders, the openness of the SIM process, and the professional relationships that exist will facilitate Delaware’s health care transformation. Additionally, stakeholders were optimistic that the Healthy Neighborhoods Model, a community-based strategy with the aim of reducing chronic disease rates and thereby improving health status, has the potential to be very successful and sustainable. These interviewees felt that reducing rates of chronic disease in communities is the way to reduce overall health care cost growth.

One additional piece of information important to the context in which the Delaware SIM Initiative is progressing is that the governorship is term-limited, and the state will undergo a change in administration at the beginning of 2017. Some interviewees described that transition as a potentially vulnerable time, and emphasized the importance of the DCHI being able to assume increased leadership as that transition occurs. On the other hand, these same individuals stated that they do not expect the gubernatorial change will have any negative impacts on the SIM Initiative, due to significant buy-in by multiple types of stakeholders. State officials noted that the high level of payer, provider, and consumer engagement provides protection from a change

in administration, because the SIM footprint is large and people are already invested in the Triple Aim²⁴ and in value-based purchasing.

A number of state and federal initiatives in Delaware predated, or are being implemented concurrently, with the SIM Initiative. These include multiple CMS Innovation Center programs: Bundled Payments for Care Improvement Initiative, Health Care Innovation Awards, Independence at Home Demonstration, Medicare Care Choices Model, and Transforming Clinical Practices Initiative

The major hospitals in Delaware are participating in Medicare Shared Savings Program ACOs, the majority of which are co-occurring with the first test year of the SIM Initiative. Other federal initiatives include funding for DHIN, funding from the Centers for Disease Control and Prevention (CDC) for health promotion and disease prevention programs, rape crisis intervention, and the Delaware Healthy Eating and Active Living Coalition; and funding from the United States Department of Health and Human Services focusing on eligibility gaps and the Maternal, Infant, and Early Childhood Home Visiting Programs.

One of Delaware's strengths is the scope of its Medicaid coverage. As one state official noted, Delaware Medicaid was ahead of the ACA—referencing the fact that Delaware expanded the Medicaid population in the 1990s. Prior to the SIM Initiative, Delaware Medicaid started requiring managed care organizations (MCOs) to participate in DHIN, which gathered beneficiary and care coordination information. DHIN's complexity and reach is growing with the SIM Initiative, as additional providers sign on to provide data.

Medicaid and commercial payers were also beginning to implement P4V models prior to Delaware's SIM award. The three primary payers in Delaware were already developing their own proprietary models for payment, including metrics that will be used to determine payments to practices. UnitedHealthcare aims to have 80 percent of all members in a P4V model by 2017—which happens to align with the preponderance of care goal for the SIM Initiative. Highmark Blue Cross Blue Shield also started pay-for-performance programs within its PCMH program prior to the SIM Initiative, and continues to roll out new programs (learning from previous programs and keeping up with the changing health care market).

Delaware's SIM Initiative is building on, and aligning with, the existing innovations in the state. To promote this alignment, the Delaware State Clearinghouse reviewed the SIM Initiative for alignment with Delaware's grant activities. Furthermore, leaders from health care systems, DHIN, and the Delaware Department of Health and Social Services (DHSS) are actively involved in alignment efforts.

²⁴ Berwick, D. M., Nolan, T. W., & Whittington, J. (2008). The triple aim: Care, health, and cost. *Health Affairs*, 27(3), 759–769. doi: 10.1377/hlthaff.27.3.759

C.3.2 Governance and program administration

Leadership for the Delaware SIM Initiative “starts at the top.” The Governor was very engaged in initial development of the Model Design application, including leading the state’s delegation in its meeting with CMMI, and continues to be very involved in SIM implementation—receiving regular briefings from staff on progress. Delaware’s HCC, as noted and shown in *Figure C-1*, above, is the lead state agency for the SIM award; and the executive director of HCC serves as SIM project director. However, as state officials said, the goal from the very beginning was to not have state government in the driver’s seat for the Delaware SIM Initiative. This is why the Operational Plan called for formation of a public/private infrastructure (the DCHI) and a stakeholder consensus process to lead the SIM Initiative. Although HCC is the recipient of the cooperative agreement, state officials repeatedly indicated that they are “not leading through mandating or legislation.” Rather, they are focused on a consensus-based approach through DCHI’s committee structure.

The chairperson of DCHI is a business leader, and this private sector leadership is purposefully designed into DCHI’s structure and operations. The Department’s Division of Medicaid and Medical Assistance and Division of Public Health also actively participate in the process, and coordinate their respective SIM-related program activities. For example, Medicaid’s new managed care contract contains specific requirements for the MCOs to implement the SIM payment reform model.

Delaware has used McKinsey & Company (McKinsey), a consulting firm, during the design and initial implementation phases of the project to assist with project administration. Initially, McKinsey performed most of the project staff functions—including project management, committee support, Common Scorecard, and payment model design. Its role is expected to diminish over time, as state agency staff and DCHI staff assume more of those responsibilities. State leadership believes that, once the design work on the Common Scorecard and payment models is completed, the consultants will assume the smaller role of subject matter experts. During the first SIM year, the five DCHI committees have gradually taken on increasing leadership of project implementation. At the time of the 2016 site visit, the executive director was the only active staff in DCHI, although she was recruiting for two additional staff. The ultimate structure and size of DCHI remains an open question. Stakeholders noted that it may remain a small organization, using or placing staff resources in other organizations to accomplish the Delaware SIM activities in the community.

The legislature has grappled with health care costs for both Medicaid and public employees, and continues to do so—voting to increase the premium contribution of state employees and working to address both a \$28.5 million shortfall in the Medicaid budget in fiscal year 2016, as well as the need for additional state funds to support the program in fiscal year 2017. However, apart from the appropriation of additional SIM funding, and the briefing of some legislative leaders, no other significant legislative involvement in the SIM Initiative occurred

until 2016. State officials and others mentioned that the second half of 2016 is the right time to step up legislative involvement, as initiatives move to implementation at the community level. They also stressed the need to coordinate any SIM efforts lawmakers undertake—in particular regarding the APCD, which requires legislative action. During the April 2016 site visit, state officials and others discussed the importance of the APCD to support the payment reform models within the SIM Initiative, and said officials were working to develop legislation creating the APCD and to secure legislative sponsors for it. Such legislation was introduced on May 13, 2016, has since been approved by both House and Senate, and signed by the Governor, and will take effect January 1, 2017.

One concern stakeholders expressed is that DCHI’s success is critical to the sustainability of the Delaware SIM Initiative. All stakeholders interviewed see the inclusion of business leaders, health care payers, and providers as part of the DCHI committee and financial support structure as the way to make the SIM Initiative sustainable for the long term. Although state leadership was very involved in 2016, the state government’s vision is that its involvement will diminish as the final year of the SIM award is reached and the private partners in DCHI assume the majority of the leadership and financial support necessary to continue carrying health system reform forward.

Another theme running through the stakeholder interviews was that, while high-ranking state officials have been involved and committed to the Delaware SIM Initiative since the beginning of the planning effort, this involvement may not yet run very deep within some organizational units of DHSS. Some felt it was important for the division leadership within DHSS to drive involvement throughout the middle management level, to further cement the SIM Initiative activities in ongoing program operations.

C.3.3 Stakeholder participation

A broad range of stakeholders in Delaware have engaged in the SIM Initiative—including providers, consumers, and payers—with the DCHI committees being a major avenue for stakeholder engagement. Membership of the Payment Model Monitoring and Patient and Consumer Advisory Committees, for example, include representatives from insurance plans, consumer groups, providers, and state officials.

Interviewees generally agreed that the state has adequately fostered stakeholder participation. One stakeholder described the relationship with the state as “very collaborative” and said their “perspectives are absolutely [taken] into account. Whether it’s agreed with or not, there is a dialogue.” However, one consumer stakeholder noted some difficulty engaging consumers, and educating them about the demonstration and how it differs from the ACA state health insurance marketplace. According to that stakeholder, consumers have a negative view of the marketplace, and they need to understand what the SIM Initiative is doing and how they can

be involved. The risk is that consumers will associate their negative views of the marketplace with the SIM Initiative.

By and large, interviewees felt that the state did take the views of health care providers and payers into account. One stakeholder noted that hospitals were more engaged than individual physicians, but the state has made an effort to get those physicians involved, especially PCPs—whose participation was described as crucial, because they directly engage with consumers. The lack of such engagement will make it much more difficult to accomplish the goals of practice transformation. PCP participation in practice transformation is critical to the success of the care coordination goal, as providers will need to adopt changes in clinical and operational practices to support the move to population-based models of care delivery.

Although health care payers are on all five DCHI committees, some stakeholders have reported difficulties getting payers engaged in the SIM Initiative. One provider commented that payers' lack of engagement has been a "disappointment." Another provider noted that one reason for lack of payer engagement is that participation in the SIM models and enabling strategies is voluntary; there is no legislative mandate to participate. A state official noted that it is critical to engage both payers and providers if the payment models are to be successful, as payers need to adopt the models within their organizations, and providers need to transform their practice patterns to achieve the metrics and associated value payments.

Although the state, providers, and payers all expressed recognition that current health care spending in the state is unsustainable, one provider described "a lot of tension" between physicians and payers. Some providers have been resistant to payment model changes because they have not traditionally tied per member per month (PMPM) and rate reimbursements to outcomes. One payer noted that it will require a paradigm shift to get providers and some MCOs to accept the changes. Some physicians are frustrated, because changes are happening too quickly, and they "don't have a voice when payers come out with a new payment model." Some believe payers should be providing more education for providers. The Payment Model Monitoring Committee is working on the best model to help physicians with the changes. The Clinical Committee is also working to help physicians adjust to the payment model changes.

As noted earlier, interviewees generally reported that Delaware is doing a good job of engaging stakeholders, although some felt that certain issues (e.g., children with special needs or disabilities) require more focus than has been evident so far. A consumer advocate commented, for example, that during meetings with physicians, "the focus was on the physician's concerns and perspectives, when I did bring up the children, I felt dismissed by some." One member of the Patient and Consumer Advisory Committee disagreed with the "good job" assessment of the state's effort to solicit stakeholder input. This person said the members of that committee generally did not have input into decisions, and that members felt they get information on a decision only after other committees have already made it.

C.3.4 Delivery systems and payment reforms

Delaware's SIM Initiative includes three forms of support for PCPs to improve their capabilities and performance: practice transformation, care coordination funding, and outcomes-based funding. State officials and others interviewed indicated that progress has varied, depending on the model and strategy. Behavioral health and primary care integration, in particular, has been slower getting started than anticipated.

Delaware has four vendors working with PCPs to support practice transformation, as noted. Multiple stakeholders explained that there are many small practices in Delaware, which can make practice transformation difficult, due to funding, capacity, and resource limitations. The contracted vendors are to provide a standard level of support (e.g., the same amount of access, frequency, training); but the content of that support is to be tailored to each PCP's needs. Recruitment for the first wave of practice transformation started in fall 2015, with the first practices beginning their work in January 2016. Delaware aims to have two or more waves to support practices needing more time to make the commitment, the second starting 6 to 12 months after the first. Delaware anticipates that SIM funding will provide practice transformation support for almost all PCPs in the state, with the option of a second-year renewal depending on practice transformation and other milestones.²⁵

Delaware's SIM Initiative encourages payer-driven adoption of alternative payment models that reward quality, experience, and efficiency. The strategy focuses on Advanced Primary Care Initiatives and allows payers flexibility in how they operationalize the two models the state is focusing on (P4V and TCC). While Delaware provides input and model suggestions, ultimately the payment models are payer-driven. Under a P4V model, payers provide bonus payments to PCPs based on quality and efficiency. Under a TCC model, payers offer providers a percentage of savings relative to a target budget, if the provider meets specific targets for quality of care measures. One Medicaid MCO is scheduled to begin P4V implementation in July, 2016, and other payers and plans are anticipated to adopt P4V models throughout 2017. The TCC model remains under development.

The P4V and TCC payment models were intentionally designed to be voluntary, to allow flexibility in model design and the timing of entry into the models. State officials heard from providers that not everyone would have the same readiness to adopt TCC, and they listened. The goal is to have all payers offer multiple options to providers for outcome-based payment models. A variety of factors have contributed to the slow pace of implementing payment reform. State officials have heard that the marketplace has impacted the financial stability of commercial payers, which is making them more hesitant to participate. It took Highmark Blue Cross Blue Shield longer than expected, for example, to create a plan that would work across state lines;

²⁵ Delaware Center for Health Innovation. (2016, May 17). *Primary care practice transformation*. Retrieved September 15, 2016, from <http://www.dehealthinnovation.org/Content/Documents/DCHI/DCHI-Primary-Care-Practice-Transformation.pdf>.

however, a provider association stakeholder noted that the extra planning was a worthwhile investment in developing an excellent final model. Medicaid redid its MCO contracts in 2015, and included care coordination requirements for the MCOs that align with the SIM payment reform strategy. Medicaid will add the specific P4V and TCC requirements for MCOs once the SIM payment reform model progresses beyond the pilot stage. As a result, not all providers will adopt P4V or TCC immediately, but the goal is to have the majority of PCPs participating over time.

Quality is to be measured under both payment models, as noted, by the Common Scorecard.²⁶ This is a critical element of the Delaware SIM Initiative that, while not enumerated as a specific initiative, is critical to success. The Common Scorecard is a set of 26 quality measures selected through a stakeholder consensus process and approved by the DCHI Board of Directors. Payers will use it to implement their individual payment models that reward provider performance on Common Scorecard metrics. The Common Scorecard, which the DCHI created to align quality measures across payers, includes measures of quality, experience, utilization, and costs. Providers and payers were both involved in measure selection, to help with measure alignment designed to reduce administrative costs and related reporting burden. The goal is for each payer to have at least 75 percent measure alignment with the Common Scorecard in their value-based contracts.

One state official said that the DCHI wanted the Common Scorecard to have a manageable number of measures across different domains, and to focus on high- risk populations. The Common Scorecard is currently being tested with a small group of providers. The Common Scorecard development and pilot have taken longer than originally planned, but the state views the lessons learned from the pilot as very beneficial for statewide implementation.

C.3.5 Health information technology and data infrastructure

DHIN was the first statewide HIE in the country. Established by Delaware statute in 2007 as a semiautonomous, nonprofit corporation, DHIN operates as a “centralized federalized hybrid” HIE model. Providers and payers submit copies of relevant data, which are then stored in segregated databases “physically separate from all other data providers.” DHIN currently receives all admission, discharge, and transfer (ADT), laboratory, pathology, radiology, and transcribed reports from hospitals in the state and surrounding areas. DHIN is expanding data collection to include ambulatory data from physician practices and has approximately 130,000 continuity of care documents in its repository from approximately 40 PCP practices. Interviewees reported that additional practices are in the process of being added.

DHIN activities predate the SIM Initiative, and although many already run parallel to it, state officials and stakeholders are all working to make sure that “everything being done is in

²⁶ Delaware Center for Health Innovation. (2016). *Common Scorecard*. Retrieved September 15, 2016, from <http://www.dehealthinnovation.org/Health-Innovation/Committees/Clinical-Committee/Common-Scorecard>.

support of SIM.” To that end, DHIN leads a Technical Advisory Group (TAG) to the DCHI to assure that electronic health information is available and functioning to support SIM’s payment reform, practice transformation, care coordination, and population health strategies.

Adoption of electronic health records. The vast majority of physician practices in Delaware are small, independent practices and the DHIN infrastructure of shared technology is intended to assist such practices to become electronic, while keeping the costs to them as low as possible. As of summer 2016, state officials’ candid assessment was that, while the major health systems have sophisticated electronic information capabilities, most physician practices are still not very far along the electronic information path. Consumer interviewees described the major health systems within the state as supporting the sharing of information among providers within their system, but said no data are shared among providers across systems. Several state officials and other stakeholders articulated the goal of cross-system data sharing as an intended outcome for the combined effort of the SIM care coordination strategy and DHIN’s continued efforts to improve health information exchange.

Care coordination requires that providers are able to share information on their patients. In 2014, 65 percent of eligible physicians, physician assistants, and nurse practitioners in Delaware had received a Medicare or Medicaid EHR incentive payment. The 2014 National Electronic Health Records Survey reports that 75 percent of all physicians in Delaware have adopted some form of EHR, below the national average of 83 percent. EHR adoption for HIE and patient engagement has been even less widespread. Less than half (43 percent) of physicians in Delaware share patient health information with any other providers; only 33 percent of physicians have the capability to exchange secure messages with patients.²⁷

Although most providers use EHRs, some expressed challenges using their EHR system. One provider expressed that the downside of using an EHR system is that it creates more stress, because there is not enough time during the day to complete the charting for patients. Several providers noted that they have to work after hours to keep up with their work. Another concern providers expressed was that the various EHR systems used by providers in the state do not “talk” to each other. However, most providers found DHIN to be helpful and useful.

One of the more challenging health IT pieces of the SIM Initiative involves long-term care. Long-term care facilities and agencies have not been part of the Health Information Technology for Economic and Clinical Health (HITECH) incentive program and still rely on paper records. Consequently, DHIN and these providers are far from being able to submit and share data. As part of an Office of the National Coordinator for Health Information Technology (ONC) grant, DHIN has collaborated with the SIM Initiative to offer long-term care facilities 2 years of no-cost secure messaging and data extracts from the Long-Term Care Minimum Data

²⁷Office of the National Coordinator for Health Information Technology. (2015, December). *Health IT Dashboard: Office-based physician health IT adoption*. <http://dashboard.healthit.gov/dashboards/physician-health-it-adoption.php>.

Set and the Outcome and Assessment Information Set long-term care facilities provide to CMS. DHIN and SIM leadership hope that the availability of this service will incentivize long-term care facilities to participate in DHIN, but progress to date has been very slow. At the time of the 2016 site visit, one skilled nursing facility and one home health agency were participating in the data extract service. The emergence of ACOs in Delaware offers an important ally in this effort. ACOs see the need to have these data, and state officials hope the ACOs can help make the business case to long-term care providers.

DHIN faces similar challenges in achieving the sharing of interoperable health data for behavioral health, as it does for long-term care. To assist in this effort, the state has budgeted \$500,000 of the Award Year 2 SIM award to support 50 behavioral health providers in their EHR adoption.

Delaware's Medicaid program has worked with DHIN on health IT prior to, and as part of, the SIM Initiative. Medicaid has participated in the HITECH program with providers, and through the SIM Initiative, and is looking at whether opportunities exist to do more in light of recent federal guidance regarding behavioral health providers and enhanced funding. Medicaid requires its contracted MCOs to participate in DHIN as data contributors and recipients.

Use of the Common Scorecard. As indicated, the Common Scorecard is a critical tool supporting SIM payment reform, practice transformation, care coordination, and population health strategies. DHIN is responsible for the technology platform and user interface associated with the Common Scorecard, and the TAG develops the metrics. Version 1 of the Scorecard was pilot tested in 21 practices during 2015. Feedback was solicited from providers, payers, and the Patient and Consumer Advisory Committee. Observations from this pilot test included that (1) creation of a Common Scorecard was a "significant change process" (2) establishing data sharing agreements with payers was time consuming, and (3) differences in payer reporting systems complicated data integration.

SIM consultants did find that providers valued individual, personal communication with each of their practices. In response, DHIN is creating a program manual and file specifications to reduce confusion and improve data quality and is developing a plan for provider outreach and enrollment to assure practices understand the Common Scorecard and its use. Version 2 of the Scorecard, to be implemented in summer/fall 2016 in a roll out to all PCPs, incorporates several new elements:

- Patient attribution information that includes both lists of a provider/practice's patients included in the performance measures, as well as a list of the patients included in the denominator of each measure. This list will also include information on whether the patient is compliant with the particular result being measured.
- Statewide metrics.
- Goal setting by payer.

Separate from the SIM Initiative, DHIN has an ONC grant to establish a statewide patient portal allowing patients to have the same access to their information that providers have. The intent is to increase consumer engagement in their personal health care.

Development of an all-payer claims database. Finally, Delaware is pursuing establishment of an APCD, as noted. Both providers and state officials acknowledge the increasing support of health systems for an APCD to achieve access to transparent and readily available claims and cost data to support their involvement in TCC payments. The APCD legislation scheduled to take effect January 1, 2017, mandates collection of Medicaid, qualified health plans in the marketplace, and state employee claims data. It also authorizes collection of voluntary data from other payers. The state believes the three mandated groups and Medicare will provide them with about 70 percent of the statewide data within the APCD. The DCHI Board recently approved a consensus white paper regarding APCD establishment, governance, and implementation. This white paper²⁸ includes sample use cases and nine recommendations regarding implementation, use, and funding.

C.3.6 Workforce development

The Delaware SIM Initiative is actively engaged in transforming its current health care workforce and training the next generation, so the state's health care system can provide team-based, integrated care. The Workforce and Education Committee, which is responsible for workforce development for the DCHI, is focused on "retraining the current workforce, building sustainable workforce planning capabilities, and training the future workforce in the skills needed to deliver integrated care."²⁹

In April 2014, Delaware held a workforce symposium to identify workforce development goals for the state. Delaware's current learning and development program includes ideas formed during the workforce symposium: (1) developing common, simulation-based learning modules; (2) facilitating local workshops on team-based care; (3) developing core competencies for new roles; (4) and hosting symposia twice yearly to highlight innovative approaches to integrating care and identify cross-state retraining needs.³⁰

The Workforce and Education Committee will also be responsible for developing a model for workforce planning to help the state develop capabilities to assess the state's workforce requirements. There will be a one-time project comparing the state's current workforce and future workforce needs. The committee will likely work with other state agencies

²⁸ Delaware Center for Health Innovation. (2016, May 11). *Increasing access to claims data to support innovation*. Retrieved September 20, 2016, from <http://www.dehealthinnovation.org/Content/Documents/DCHI/DCHI-Perspective-Increasing-Access-To-Claims-Data.pdf>.

²⁹ Delaware Center for Health Innovation. (2017). *About the Workforce and Education Committee*. Retrieved September 20, 2016, from <http://www.dehealthinnovation.org/workforce-education>.

³⁰ Delaware Center for Health Innovation. (2016, March). *State Innovation Model Operational Plan*. Retrieved February 7, 2017, from <http://www.dhss.delaware.gov/dhss/dhcc/files/simoperplanyear1.pdf>.

and organizations (including HCC) to accomplish this goal. One early area of interest is standardizing training for community health workers and making them a recognized discipline within the health workforce, such that Medicaid and commercial insurance payments can be used to support their activities.

Finally, the Workforce and Education Committee will partner with educational institutions in the state over the next several years—to provide training to current and new members of the workforce, to ensure it has the skills and capabilities required to provide integrated care to the state’s population.

C.3.7 Population health

Delaware’s population health efforts largely focus on the Healthy Neighborhoods initiative, although SIM leaders were quick to point out that the entire Delaware SIM Initiative is aimed at improving population health. Healthy Neighborhoods is an innovative approach to population health, designed to support communities coming together in new ways to develop and implement locally tailored solutions to some of the state’s most pressing health needs. The program provides a framework for community development and formal partnerships across organizations, and supports communities with resources and expertise as they work to make real changes—enabling healthy behavior, improving prevention, and facilitating better access to primary care for their residents. Each of 10 planned Healthy Neighborhoods will develop and implement a 3-year strategy to improve health in one or more of the following four priorities, depending on individual community needs: (1) healthy lifestyles, (2) maternal and child health, (3) mental health and addiction, and (4) chronic disease prevention and management.

Each Healthy Neighborhood will determine what program success will look like for them, and will create a plan for collecting and analyzing data—including, but not limited to, community engagement, service utilization, client satisfaction, health status measures, and cost savings. Individual Healthy Communities will be responsible for monitoring and evaluating their own initiatives, including progress and outcome goals. Throughout the 2016 site visit, interviewees repeatedly mentioned Healthy Neighborhoods as the model thought most likely to impact Delawareans’ health in the long term.

C.3.8 Technical assistance and other support resources

State officials said they feel well supported by the SIM program team. In fact, sometimes there is so much information, according to one official, that it is difficult to find the time to digest it all. Another state official reported that CMMI has been responsive to questions about SIM report submissions. State officials also said they find it helpful to hear directly from CMMI about its vision of the SIM Initiative. Overall, stakeholders reported positive experiences when they reached out to CMMI for guidance.

C.3.9 Progress, challenges, and lessons

Several state officials indicated that the state had been thinking for some time about health care delivery transformation and how to accomplish it. The SIM Round 1 Model Design award provided the opportunity to create a formalized structured venue for development and consensus, and resulted in formation of the DCHI. The Round 2 Model Test award has provided the opportunity to bring together diverse stakeholders through the committee structure to develop specific plans to achieve the SIM goals identified. One state official described the past year as being one of “transformation of thought.” While a small group of state officials and stakeholders had long believed in the SIM goals and initiatives, according to many interviewees, the committee efforts of the past year have resulted in all stakeholders now believing in them. Those interviewed felt that (1) this only happened because of the dedication of the stakeholders to “be willing to sit around the table together until we got it right”; and (2) now “it’s time to...put that thought into action.”

Delaware’s progress with its SIM Initiative has provided some key lessons learned and advice for other states that may be embarking on similar initiatives. A common theme expressed by stakeholders is that everything takes longer than anticipated. This lesson has been particularly true with the payment models, which required payers to not only engage with DCHI committees, but also coordinate with the payers’ national offices regarding enterprise initiatives and quality reporting metrics. One stakeholder described the importance of being transparent and communicating with stakeholders and project administration about what is not working in order to move forward with a new solution.

Stakeholders had a variety of answers when asked what they would do differently in planning the SIM Initiative. Recognizing the impact of legislative initiatives, one state official noted that including the legislators earlier could have facilitated policy support for the SIM Initiative through sponsorship and passage of necessary legislation, such as that to establish the APCD. As one state official suggested, restructuring the Division of Public Health to make it more of a policy driver could be one approach to increasing legislative support for the SIM Initiative by integrating the budget and operational sides of the Division with the health care planning side.

Delaware deliberately made its payment model voluntary, as noted, and is providing optional payment reform models—a decision stakeholders acknowledge as increasing risk. Since there is no regulatory pressure for payers to align with the SIM Initiative, their involvement has been slower. As previously mentioned, factors such as financial instability have impacted the commercial payers’ progress in implementing value-based payment models. One state official acknowledged that the payers’ budgets may look different than they did 3 years ago (in the design phase). If payers fail to commit, SIM Initiative leadership will need to reevaluate how to leverage other resources.

Another challenge has been communicating the SIM Initiative to the general public. One consumer advocate explained that many people have a negative view of the ACA marketplace. Therefore, the marketing plan needs to communicate how the SIM Initiative differs from the marketplace and how consumers can get involved in the SIM Initiative. The DCHI is currently working to help consumers understand the SIM strategies and the positive changes that they, as consumers, can expect.

Previous stakeholder engagement focused on payers, hospital systems, and providers to develop health care reform implementation strategies. A state official acknowledged that they should have started SIM consumer outreach sooner, because consumers do not know about the SIM Initiative and why it is important to them. The state has said that there were opportunity costs paid in not beginning messaging and grassroots effort with consumers earlier. One cost was not having patients that could drive the demand for care coordination services, and thereby provide an impetus for providers to participate in practice transformation. The state attributed the lack of consumer outreach to not having defined the messages around the value proposition of SIM Initiatives for consumers. Consumers will be engaged through the Healthy Neighborhoods implementation and through a series of six town hall meetings hosted by DCHI throughout the state. State officials also hope to use community leaders to help spread the SIM message. In addition, the state has plans to reach out to private employers not already engaged in the effort, to inform them about the SIM Initiative and gain their interest and support.

Some interviewees confirmed the belief that patient engagement, specifically, has been a lower priority during this first year than it should have. The series of six town hall meetings began in May 2016, and a concerted outreach strategy to build public awareness of the SIM Initiative (including print, television, and radio) was scheduled later in the year. Delaware has also launched a new public portal for the SIM Initiative, designed to address the need for patient and consumer engagement.

One uncertainty going forward is the amount of funding expected to come from payers. The total SIM Initiative budget is \$130 million, with a \$35 million award from CMS and the remaining \$95 million from stakeholder contributions. The largest portion of the \$95 million is to be in the form of Care Coordination payments. The original amount for Care Coordination was anticipated at \$60 million. Given that payment model implementation was delayed, these payments will not be scheduled to go out until 2017; some concern was expressed by stakeholders that the longer it takes to get to the point of payments, the less secure providers will be that these payments will actually occur.

Other funding concerns include uncertainty surrounding the DCHI's future funding. Stakeholders have committed funding for the DCHI its start up, but its future sustainability depends on its being able to prove its value to those private-sector stakeholders, which can be challenging. The one funding modification to the original plan was based on the growing sense that the Wave 1 Healthy Neighborhood communities would need some startup funding to begin

their work. However, Delaware was not confident that the level of stakeholder engagement would be sufficient to roll out the Healthy Neighborhoods model. Concerns stemmed from the lack of established infrastructure, due to challenges in hiring staff at DCHI to support the Healthy Neighborhoods initiative. As a result, SIM administrators reallocated the budget to use \$600,000 to support the DCHI's staff to help the Healthy Neighborhoods communities. Delaware has worked to maximize the efficiency of funding and resources by aligning SIM activities with existing public health initiatives in the state.

A major theme emphasized by many interviewees is that Delaware has spent the first year of the award taking the original vision for the Delaware SIM Initiative and creating the implementation strategies. State officials viewed the past year as an opportunity to cement the SIM goals and initiatives in the thought process and actions of stakeholders. Interviewees expressed the feeling that the payment models and enabling strategies are now poised to get under way, and need to begin quickly to assure sustainability. According to this view, the state successfully achieved high stakeholder engagement for model development and now needs to work hard to maintain this involvement. The DCHI committee structure was described as essential to this result. Stakeholders know that transforming the state's health care system is a long process, but hope that the state will be able to gain the momentum and interest to continue the high level of stakeholder engagement as the specific initiatives begin to roll out.

C.4 Statewide Changes

C.4.1 Health care expenditures

Three of the SIM strategies being implemented are expected to impact health care expenditures: payment model reform, care coordination, and Healthy Neighborhoods. Interviewees said they believe SIM success will lead to greater value and bending the cost curve (i.e., slowing the rate of increase).

While Delaware has not provided details on what achieving greater value will look like, the state has thought through its intentions with respect to bending the cost curve. As depicted in the statewide impact column of the logic model (*Figure C-2*), the state hopes to lower health care costs. This objective will be evaluated by Delaware through the Common Scorecard TCC per patient measure. Based upon preliminary financial analyses, Delaware expects providers that participate in a TCC payment model to achieve gross savings of 8 to 10 percent (versus projected baseline) over 5 years. Providers that participate in a P4V model are expected to experience more modest rewards tied to more modest performance targets—achieving three percent gross savings over the same 5-year period. Overall, Delaware expects to create \$282 million in cost-of-care savings through 2018 and \$3.8 billion through 2024; the majority of savings in the early years will be reinvested in the delivery system.

C.4.2 Health care utilization

The main issue discussed by stakeholders related to health care utilization in Delaware is inefficiency in the availability of services, particularly resource-intensive specialty services. Health care systems have traditionally been competitive with one another in the state, even though there is not much overlap in the populations they serve. Exemplifying this is the duplication of expensive services, such as cardiac surgery and cancer treatment programs. Because the state is not very large, geographically or in population, neither of the two existing programs in these areas is able to achieve sufficient patient volume to support its investments in personnel or technology. Patients would be more efficiently served if each system selected one area in which to develop capacity and depth, and allowed the other system to do the same in another specialty area. A similar issue exists with treatment of multiple sclerosis. There is only one specialist in the state, and not enough patients to efficiently support even this practice. Thus, it would be more efficient, and patients might be better served, if these services were provided by the large multiple sclerosis programs that currently exist in nearby Philadelphia or Baltimore, where larger patient volumes justify the specialty. One provider stakeholder expressed hope that issues related to health system competition will be addressed through examination of utilization patterns within the state.

Delaware's utilization of emergency services is one of the highest in the nation. While the SIM Initiative is attempting to decrease utilization of emergency services, a provider representative commented on the planned expansion of emergency services within the state. Patients are more likely to seek care at emergency rooms (ERs), even when the care can be provided in other care settings. And because the same procedure is reimbursed at a higher rate when provided in the ER, compared to a primary care setting, health care systems are inadvertently incentivized not to discourage patients from seeking care in their ER in cases where the patients could be more efficiently seen in lower-cost settings. The health care systems are actually planning to increase the number of emergency services offered in the state to meet patient demand—a plan they acknowledge goes against the very intent of the SIM Initiative. However, until they see impacts of care coordination efforts, stakeholders expect patients to continue to seek services through their ER.

The Medicaid beneficiary focus group's discussion about the ER reflects this high utilization. All nine of those focus group participants had been to the ER in the past year, and five of these visits led to hospitalizations. Reasons given for using emergency services included: instructions from a PCP telling the beneficiary to call an ambulance because of pneumonia; needing care when the primary care office was closed; and health needs from asthma attacks, car crashes, falls, and pain. One beneficiary said, "I go straight to [the] ER. Don't take a gamble with my life. I don't play. At least I get seen." This sentiment was shared throughout the Medicaid focus group, where the ER was seen as an acceptable alternative to primary care when sick. The state employee consumer focus group participants discussed using the ER less, in contrast, and instead said they were able to see their PCP when sick.

Both the Medicaid beneficiary and the state employee focus groups found that it took longer to get an appointment with a specialist than a PCP, particularly if they had a provider preference, but that it was possible to see specialists. Five of the nine Medicaid beneficiaries were able to see behavioral health specialists at no out-of-pocket cost. But many expressed frustration that they needed to choose between dental or vision coverage; both were viewed as essential health needs. Thus, while burdensome, many said they switched plans every year to get both types of services covered in a timely way.

Delaware's SIM Initiative addresses health care utilization through its payment models, practice transformation, integration of behavioral health and primary care, care coordination, consumer education, and APCD. Payment models, particularly P4V, will incentivize examination of utilization patterns among patient panels. Practice transformation addresses utilization by ensuring access, and perhaps even priority scheduling, for high-volume ER patients at urgent care centers where their health care needs can be more efficiently met. The integration of behavioral health and primary care model addresses utilization of ER and primary care services by patients with chronic diseases, who also have behavioral health needs. The care coordination model addresses utilization in two specific ways—reducing ER overutilization and reducing readmission among patients undergoing a care transition. Additionally, patient education relating to where to seek care is part of the SIM practice transformation initiatives; consumer education and empowerment, along with health literacy, address the issue of assisting patients in finding the right services to meet their health care needs.

Interviewees saw the APCD as the source of information to identify and better understand variation in utilization—as providing a centralized, third-party database of claims across the continuum of care. The APCD is expected to illuminate key drivers of such variations and provide a fact-based assessment of the value of specific health care services. Currently, claims information is described as limited and fragmented, typically available only within each payer's information systems. In addition to providing unparalleled transparency, the anticipated, large sample size of the APCD is expected to enable more rigorous data analysis.

To monitor the success of Delaware's efforts to improve health care utilization, DCHI will use the Common Scorecard to measure health care utilization for the SIM Initiative. Four utilization measures are included: (1) follow-up within 7 days of discharge for congestive heart failure, chronic obstructive pulmonary disease, pneumonia, and ischemic vascular disease; (2) all-cause unplanned readmissions; (3) inpatient utilization; and (4) ER utilization.

C.4.3 Care coordination

While the state employee focus group participants expressed the need for improved care coordination in Delaware, Medicaid beneficiaries affiliated with the same health care system in Delaware had positive experiences with their current care coordination—which they described as facilitating provider-to-provider communication. Additionally, four out of the nine Medicaid

focus group participants had either a social worker or care coordinator. However, no one in the state employee focus group felt their PCP coordinated with their specialists; rather, these patients said they had to initiate the communication between their providers. Consumers in both focus groups saw the capacity for EHRs to improve care coordination, and were excited to learn more about the potential benefits of portals, such as being able to request refills. However, many found the current systems available to them difficult to set up and use.

Delaware SIM leaders' vision is that all Delawareans should receive convenient, effective, well-coordinated care throughout the health care system, and that coordinated care is foundational to achieving the Triple Aim.³¹ For Delaware, the goal of care coordination is to facilitate appropriate delivery of health care services and to optimize health outcomes. The state sees very tangible benefit to developing a common framework for the key elements of care coordination related to expectations, funding, support, and participation; and to that end, they prepared a white paper detailing this thinking.³² They also recognized that the way providers implement care coordination may vary based on differences in provider scale and structure, and in patient needs. The three critical elements to achieving care coordination, as laid out in the white paper, are practice transformation support, care coordination funding, and outcome-based payments to providers. Success of the care coordination initiative will be measured through improvements in the Common Scorecard measures.

Care coordination funding is expected to help providers coordinate care between patients' office visits and with other health care system encounters. Specific goals include effective follow-up after acute events and hospitalizations, development of care plans, and integrated care for patients with behavioral needs.

Several of the core processes of effective care coordination include timely access to data to identify patients in need of care coordination and connectivity support across providers on multidisciplinary teams. The SIM Initiative is planning development of resources to support care coordination including (1) an initial list of high-risk patients from payers, (2) ADT data from DHIN, (3) quarterly data on Common Scorecard performance, (4) training to make effective use of practice-level data from practice transformation vendors, and (5) EHR funding for behavioral health providers.

In the RTI team's discussions of care coordination with stakeholders representing health care organizations, several expressed concerns that clinicians perceive payers as potentially not paying enough to make care coordination worthwhile for providers. While not directly addressing the size of care coordination payments, however, one payer was optimistic that care coordination would be successful in improving health care delivery in Delaware. This

³¹ Berwick, D. M., Nolan, T. W., & Whittington, J. (2008). The triple aim: Care, health, and cost. *Health Affairs*, 27(3), 759–769. doi: 10.1377/hlthaff.27.3.759

³² Delaware Center for Health Innovation. (2016, January 13). *Care coordination as an extension of primary care*. Retrieved September 20, 2016, from <http://dhss.delaware.gov/dhss/dhcc/files/carecoordination.pdf>.

stakeholder believed that the critical piece is tying the PMPM payments to outcomes; and that the Common Scorecard will assist in setting goals for attributed patient panels, which are likely to be ultimately successful and sustainable because of the monetary resources behind the Scoreboard.

Along with concerns about the size of care coordination payments, stakeholders noted another risk to the success of care coordination—not knowing how much work will ultimately be involved, as vendors are only now in the stage of identifying PCPs and assessing capacity.

C.4.4 Quality of care

While our site visit interviews with the state and other stakeholders did not provide information specifically on the current state of quality of care, the consumer focus groups provided some insight. Participants in both consumer focus groups ranked their providers highly on a 10-point scale (the majority ranked 7 to 10), and shared that their providers take time to talk with them about their medication and health. Six Medicaid participants said that they received written instructions at the end of appointments; two, that they were referred to weight loss classes; three, that they were referred to smoking cessation classes; and one, that she or he is currently taking a nutrition class.

For Delaware, quality of care is closely tied to three of its SIM Initiative strategies—care coordination, outcome-based payments, and Healthy Neighborhoods—and is an important component of all three. Care coordination is expected to increase the quality of care for patients identified as high-risk through better provision of preventive health services. Payers are encouraged to qualify PCPs for care coordination funding if they achieve reasonable performance standards for quality of care, the criteria for which must be based in whole or in large part on quality measures drawn from the Common Scorecard. Outcome-based payments are expected to increase quality of care, by incentivizing providers to practice evidence-based medicine as measured by the Common Scorecard. Healthy Neighborhoods are expected to increase quality of care by addressing community health priorities through a stakeholder-diverse population health approach—although details of the mechanism were not available for this report.

Delaware will monitor 21 quality measures from the Common Scorecard as the primary means to measure success, but specific targets for these measures have not yet been identified. In addition to these Common Scorecard measures, as Healthy Neighborhoods Councils form across the state and begin their work in communities, analytic reports based on data from the APCD will be used to assess and track quality outcomes.

C.4.5 Population health

Delaware has a higher than average prevalence of obesity (14.2 percent compared to 13.7 percent nationally); and the rate is rising, particularly among children. The prevalence of

diabetes and prediabetes in Delaware is 9.6 percent (compared with 7.6 percent nationally), and nearly 20 percent of adult Delawareans are smokers. Thus, Delaware has identified obesity, diabetes, and tobacco as specific population health priorities.

Population health goals for the SIM Initiative will be largely addressed through the Healthy Neighborhoods model, although the entire SIM Initiative is described by DCHI as focused on achieving improvements in population health. By attributing all patients to a PCP and incentivizing PCPs to address these three specific measures as well as total cost, Delaware's payers are shifting incentives to support population health.

Each Healthy Neighborhood will form a multi-stakeholder local council to represent their community and engage with DCHI staff in program planning and implementation. The councils will also be responsible for regularly assessing implementation and monitoring progress toward goals. No further information about specific measures of success for these initiatives is currently available—although stakeholders said a Population Health Scorecard is envisioned as one means to track progress in the Healthy Neighborhoods initiative, and the APCD as another.

C.5 Overall Delaware Summary

In the first year of SIM implementation, Delaware has realized progress. Establishment of the DCHI and the governance structure required extensive engagement of diverse stakeholder groups in a consensus-based process, many of whom had not previously worked together. The committee structure and the planning work these committees have undertaken have resulted in clear operational plans and white papers for all aspects of the SIM Initiative. The Healthy Neighborhood communities have been identified, and two of the Wave 1 communities have begun establishing their local councils. Practice transformation vendors have been contracted and are starting to work with participating practices to assess their readiness, and to help them develop capacity, to perform the care coordination and quality reporting activities essential to the P4V Model. A Learning and Re-Learning Curriculum with six areas of focus has been developed as part of the workforce initiative. Throughout the state, stakeholders are engaged and optimistic about how the SIM Initiative can impact health across Delaware.

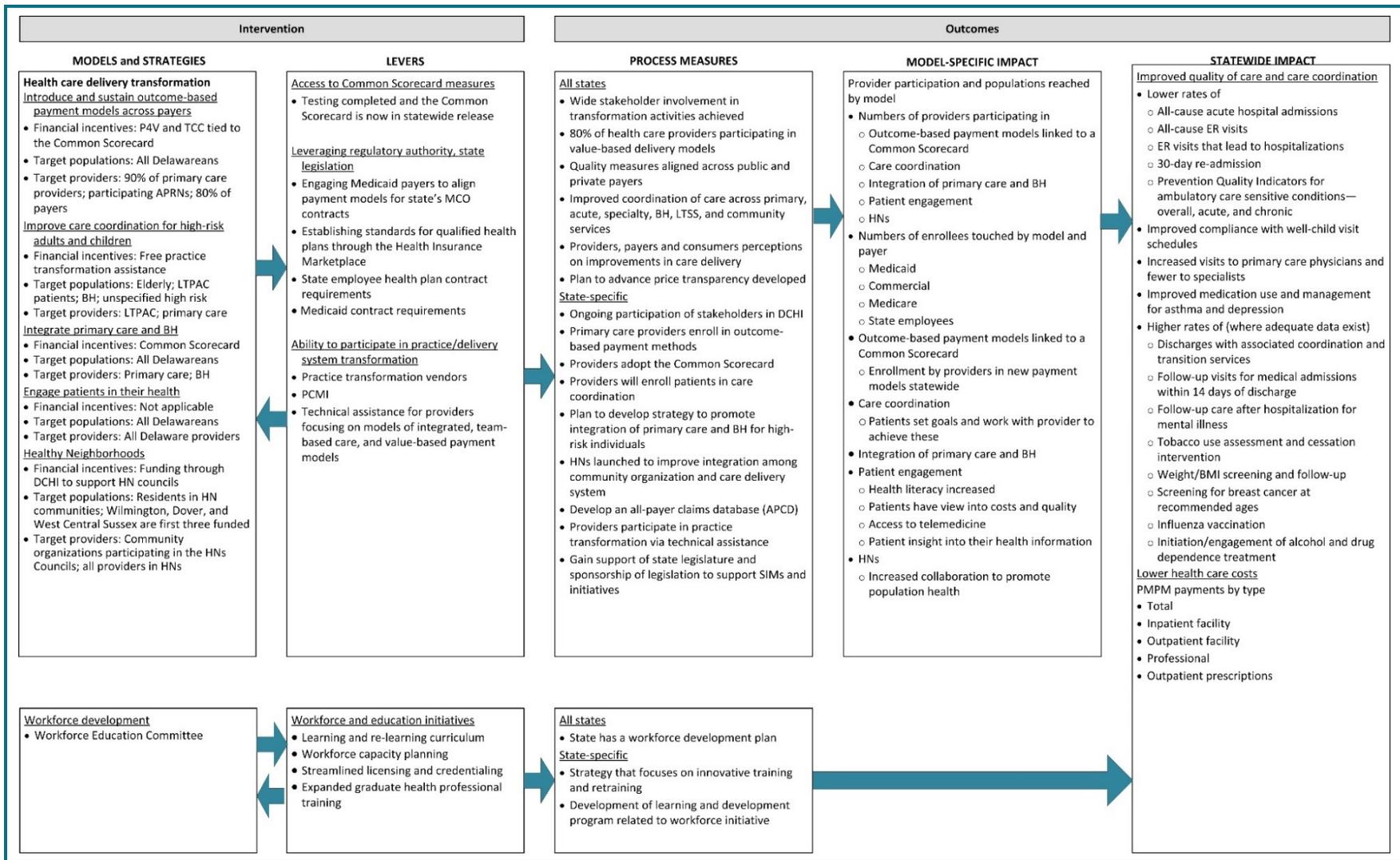
While still at an early stage at the time of the 2016 site visit, a number of SIM implementation aspects will be monitored by the evaluation team over the coming year. First, the DCHI, with additional staff positions filled, will be stepping up to lead implementation with less reliance on consultants. In particular, the DCHI will provide staff support to the Healthy Neighborhood communities. Second, education for and involvement of primary care practices should be closely monitored and supported throughout the state. Stakeholders voiced some concern that most PCPs in Delaware are unaware of the SIM Initiative, even though their participation is crucial to its successful execution. Participation of primary care practices in practice transformation through the technical assistance vendors have rolled out. Continued

attention will need to be paid to how practices are leveraging those services to move care coordination forward.

Third, engagement of all payers and roll out of the payment models will be critical to SIM success. Fourth, progress in rolling out the information systems that will receive and store data and produce outcome measures (upon which the success of SIM will be based) should continue to move forward over the next year. These systems include the Common Scorecard and the APCD. Finally, based on site visit interviewees, consumer and patient engagement efforts will also require continued focus. Additional awareness and support for SIM should become evident if the recent new activities in this area are effective.

While all these steps forward are significant, everyone interviewed expressed confidence that Delaware is well positioned for success, given stakeholders' common understanding of the changes that need to occur and their deep commitment to health system change.

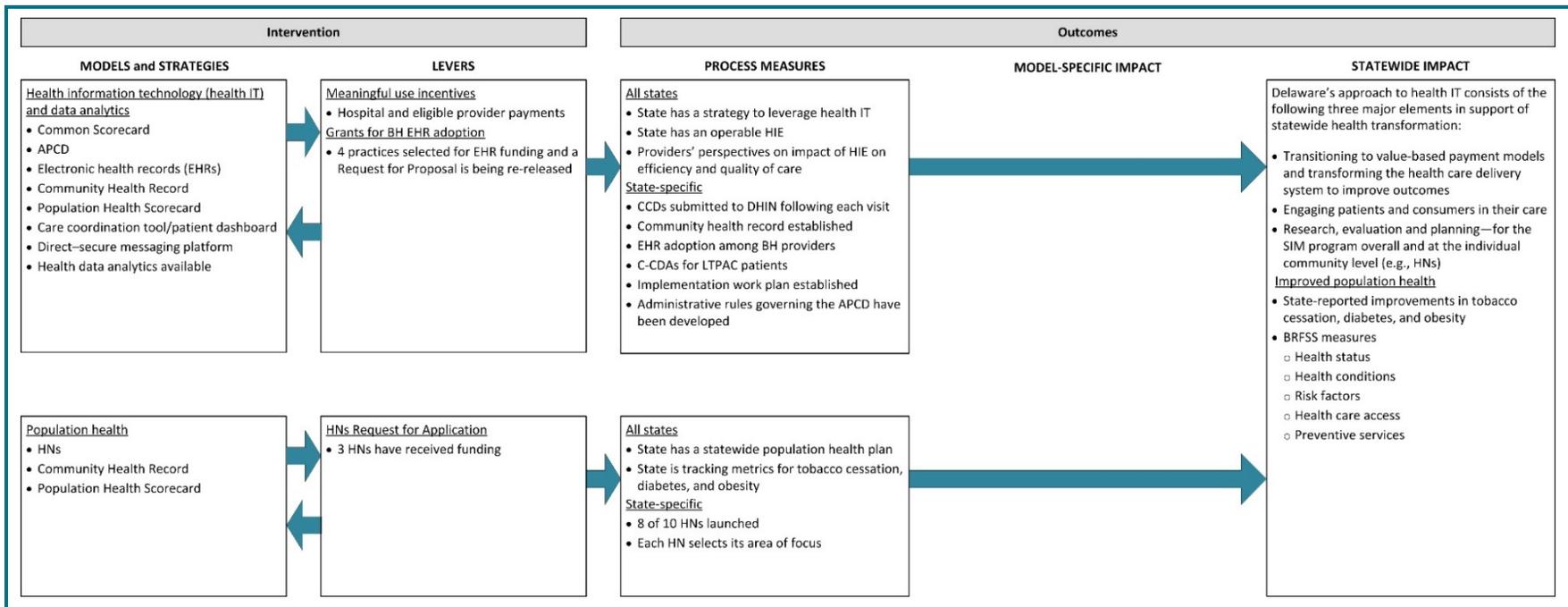
Figure C-2. Logic model for Delaware’s State Innovation Model activities



C-25

(continued)

Figure C-2. Logic model for Delaware’s State Innovation Model activities (continued)



C-26

APCD = all-payer claims database; APRN = advanced practice registered nurse; BH = behavioral health; BMI = body mass index; BRFSS = Behavioral Risk Factor Surveillance System; DCHI = Delaware Center for Health Innovation; DHIN = Delaware Health Information Network; EHR = electronic health record; ER = emergency room; health IT = health information technology; HIE = health information exchange; HN = Healthy Neighborhood; LTPAC = long-term and post-acute care; LTSS = long-term services and supports; MCO = managed care organization; P4V = pay for value; PCMI = Program on Chronic Mental Illness; PMPM = per member per month; SIM = State Innovation Model; TCC = total cost of care.

Appendix D: Idaho Site Visit Report

For the 2016 site visit, the RTI team conducted key informant interviews and provider and consumer focus groups in the Boise area from May 24 through May 26, 2016. The team also conducted one phone interview, for a total of 18 interviews. The focus of the interviews was to learn about the context of the state's health care system and early SIM implementation successes, challenges, and lessons learned to date. The interviews included state officials, payers, providers, and consumer advocates involved in the development and implementation of Idaho's SIM Initiative. The team also conducted two focus groups with Medicaid beneficiaries and two with providers who accept Medicaid, to learn about their experiences with the current health care system in the state and their awareness of the SIM Initiative.

This appendix provides an overview of the Idaho SIM Initiative; describes the current health care context in which the SIM Initiative is being implemented; summarizes early implementation successes, challenges, and lessons learned; and discusses key findings from the site visit interviews and focus groups organized by major topic area. This appendix includes findings based on qualitative data collected through June 30, 2016. Further details on the analytic approach are available in *Appendix L*. Information on the site visit interviewees for the state is in *Table L-1*, and information on the provider and consumer focus group participants for the state is in *Tables L-4* and *L-5*, respectively.

D.1 Overview of Idaho's State Innovation Model

Idaho's SIM Initiative aims to improve health outcomes, improve quality and patient experience of care, and reduce health care costs by \$89 million by 2019. The Idaho SIM Initiative is intended to transform Idaho's primary care system into one of patient-centered medical homes (PCMHs) operating within an organized medical/health neighborhood. In February 2014, the Governor established the Idaho Healthcare Coalition (IHC), which comprises key stakeholders from both the private and public sectors, to guide SIM implementation. The plan rests on seven goals that, when achieved, stakeholders expect to produce and sustain delivery system transformation:

- ***Transform primary care practices across the state into patient-centered medical homes.*** Over the course of Award Years 2-4, Idaho plans to build 165 PCMH primary care practices (defined as a clinic site; 55 clinical sites per year over 3 years), involving 825 primary care providers (PCPs) and serving 825,000 residents. SIM funds will provide training and technical assistance (TA) to these 165 practices. In addition, these practices will receive lump sum payments for achieving certain milestones, such as securing recognition from a national accrediting body (e.g., National Committee for Quality Assurance) as a PCMH.
- ***Improve care coordination through the use of electronic health records and health data connections among patient-centered medical homes and across the medical/health neighborhood.*** Idaho is working to strengthen and expand

participation in the Idaho Health Data Exchange (IHDE), which is Idaho's statewide health information exchange (HIE). The IHDE is building new capacities, such as the ability to receive data from the electronic health record (EHR) systems of PCMHs, disseminate the data as needed to other providers, and process the data into quality metrics for value-based payment (VBP) and quality assurance. SIM funds will be used to provide TA in the connection process and pay the IHDE fees for the 165 participating clinics. These practices will also receive TA to help them use the data from the IHDE, in combination with their EHRs, to coordinate patient care.

- ***Establish seven Regional Health Collaboratives to support the integration of each patient-centered medical home with the broader medical/health neighborhood.*** Idaho is creating seven Regional Health Collaboratives (RCs) through the state's existing seven Public Health Districts (PHDs). The RCs will serve a key role in drawing from local area expertise to ensure community and regional needs are addressed through the SIM Initiative. They are, in conjunction with local stakeholders, tasked with organizing the broader medical/health neighborhood within which PCMHs will work. Idaho sees this broader neighborhood as including hospitals, specialists, other ancillary providers, and nonmedical community-based organizations.
- ***Improve rural patient access to patient-centered medical home by developing virtual patient-centered medical home.*** Because Idaho is predominantly rural, it has established a specific goal of providing access to PCMHs in rural areas. Idaho plans to build up to 50 virtual PCMHs during Award Years 2-4. A virtual PCMH is one that provides one or more of the following services: (1) telehealth services including specialty care, behavioral health care, and/or mobile emergency medical services (EMS) units; (2) trained community health emergency medical services (CHEMS) personnel; or (3) trained community health workers (CHWs). PCMHs that become virtual PCMHs will also receive payment for that accomplishment.
- ***Build a statewide data analytics system that tracks progress on selected quality measures at the individual patient level, patient-centered medical home level, regional level, and statewide.*** Idaho plans to implement a statewide data system that can be used to assess health system performance and support improvement at multiple levels in the system. This system will be linked to the IHDE but will use data from multiple sources to track performance.
- ***Align payment mechanisms across payers to transform payment methodology from volume to value.*** Idaho expects 80 percent of payments to be made through value-based models by the end of Award Year 4. These will include per member per month (PMPM) fees for PCMH, total cost of care, and other risk-sharing models that consider provider achievement of quality outcomes.
- ***Reduce overall health care costs.*** Idaho anticipates providing the sustainability of its transformation by demonstrating the value of that transformation, so payers will continue to participate in the model beyond Award Year 4. Idaho intends its transformation to improve health outcomes, improve quality and patient experience of care, and reduce health care costs, as noted, by \$89 million by 2019.

Idaho has identified several state-specific goals for its SIM Initiative. For example, the state is aiming for 80 percent of payments to be made through value-based models and for 50 percent of Idahoans to be receiving primary care from a PCMH by the end of Award Year 4.

D.2 Logic Model

Figure D-1, located at the end of this appendix, is a logic model of Idaho’s SIM Initiative, depicting the hypothesized relationships between specific elements of the SIM Initiative and changes in outcomes. Columns 1 and 2 are related to Idaho’s intervention. The columns describe the primary model of the SIM Initiative (PCMHs), list the support structures that will accompany the model (workforce development, health information technology [health IT], the population health plan, and infrastructure), and describe the levers used by the state (e.g., executive orders, state plan amendments, contractors).

Columns 3, 4, and 5 describe the expected outcomes from the model. Several process measures are expected to improve, such as more payments made under value-based agreements, increased coordination of care, and more CHWs. Beneficiaries served by transformed practices are expected to have better access to more coordinated, safer, and higher quality care, as well as to have better patient experiences with care and be more engaged in decisions about treatments and management of their condition. These enhancements are, in turn, expected to reduce hospital admissions and emergency room (ER) visits, increase compliance for preventive care, and improve medication management—ultimately resulting in lower health care expenditures and better health.

D.3 Implementation Activities

D.3.1 Context of health care system

Idaho is a rural state with a shortage of both PCPs and behavioral health providers. Recognizing the need for innovation and meaningful change, state officials, providers, and other stakeholders viewed the SIM Initiative as an opportunity to improve primary care and implement payment reform. In a state with a political context that values fostering consensus among stakeholders rather than efforts that are government-driven, the SIM Initiative, with the Governor’s support, has developed as a flexible public/private partnership approach to improving the state’s health care delivery system.

The SIM Initiative builds on several of the state’s strengths. Most importantly, the public and private sectors in Idaho have a long history of working together to advance the PCMH model. In 2009, the state received a grant from the Commonwealth Fund focused on transforming safety-net primary care clinics into PCMHs. In 2010, through executive order, the Governor created the Idaho Medical Home Collaborative (IMHC) to pilot and test the feasibility of a multi-payer PCMH model within the state. In the years since then, Idaho has secured additional support from the Commonwealth Fund, the Agency for Healthcare Research and

Quality, and others to continue these efforts. Most recently, CMS selected Idaho into the Innovation Accelerator Program, through which the state will work to integrate behavioral health and primary care. Numerous stakeholders emphasized the importance of the success of this previous foundational work. They indicated that it created a widespread understanding of the value of the PCMH model among clinics and other stakeholders, a nucleus of experienced PCMHs with practical knowledge about implementing the model to inform and support Idaho's new efforts, and strong working relationships among most of the key stakeholders needed to implement the SIM Initiative.

Stakeholders also identified the structure of the public health system as a strength that will enable the RCs' success. Idaho's local public health system is composed of seven health districts independent of state government—although they work closely with the Idaho Department of Health and Welfare (IDHW) and other agencies. A board of health appointed by county commissioners in the region directs each district. Idaho established this design to ensure each district is directed by local leadership and responds to local needs—very similar to the vision for RC structure and leadership. Stakeholders believe the health districts offer a strong platform for building the framework of the RCs and engaging the expertise of local stakeholders. Thus, the SIM Initiative places responsibility for convening the RCs with the districts. State officials indicated they believe this structure will bring public health expertise to the table in each area of the state, and enable the RCs to combine the expertise of public health and primary care.

Although the SIM Initiative builds on Idaho's strengths, stakeholders did identify two contextual factors relevant to its implementation. First, a wide range of stakeholders are actively involved in implementation efforts. These stakeholders include state officials, providers, payers, health association representatives, and consumer advocates. Some groups, however, such as self-funded employers and oral health providers, initially were not engaged by the state but have been more involved since requesting to participate. Other stakeholders (e.g., payers) indicated that, while they are supportive of SIM goals, they were not included in the early stages; as a result, they did not have the opportunity to inform some of the SIM approaches to payment transformation. Many stakeholders identified payer engagement as the greatest challenge SIM implementation currently faces. For example, some payers initially expressed uncertainty that investments in primary care could lead to reduced costs, and were also hesitant to become involved prior to more widespread provider engagement. Payers also indicated that, although they support the movement toward more VBP, they have reservations about the PMPM model the SIM leadership was encouraging payers to implement.

The second factor is that stakeholders reported (and provider focus groups confirmed) that few providers exchange data through the IHDE, although more can view the data in that system. Most large health systems and practices have EHRs but may not be connected to the IHDE. Also, practices that have implemented EHRs have chosen a variety of EHRs that record

information differently. Most health care coordination occurs via telephone and fax. Some stakeholders are concerned that it may be difficult to meet SIM's goals for electronic exchange of information.

When asked to consider the SIM Initiative within the context of the state health care environment, almost all stakeholders reported that they saw creating statewide access to PCMHs as both the most significant part and, because they were building on previous efforts, the one the state was most likely to succeed in implementing. They considered the PCMH to be the key driver for achieving the state's primary aims to improve health outcomes, improve quality and patient experience of care, and reduce health care costs. Most also named the RCs as a significant strategy that was likely to succeed, although some were concerned about the RCs' sustainability after the end of Award Year 4—as they felt it was not yet clear who would pay for these entities or how payment would be structured after that period. Others mentioned the importance of the virtual PCMH to improving access to primary care in rural areas. Finally, many agreed that payment reform was critical to sustaining health system transformation. Most of these stakeholders went on to say they saw Medicaid as a leader in this area, and were concerned that commercial payers were not following Medicaid's lead in moving to a PMPM payment model for PCMHs, as originally envisioned for the SIM Initiative.

Because Medicaid only provides health insurance to roughly 11 percent of Idaho's population as of 2013,³³ engagement and participation by commercial providers will be critical to SIM's success. Idaho's commercial insurance market is concentrated, with one dominant insurer, Blue Cross of Idaho, the largest insurer in the individual (51.1 percent), small group (49.4 percent), and large group (66.8 percent) markets in 2013.³⁴ In the same year, there were six insurance carriers in Idaho's small group market, seven in the large group market, and five in the individual market; and few insurers had more than 5 percent of market share in each market: two in the large group, three in the small group, and three in the individual market.³⁵ Finally, 57.5 percent of workers with employer-sponsored health insurance are covered by self-funded employers. Currently, the large commercial payers, including Blue Cross of Idaho, are pursuing their own VBP models, though not in the same form as Medicaid. To date, no self-funded employers are explicitly participating in the VBP reforms, though representatives stated that there is interest in transforming the payment models if the value can be demonstrated.

³³ State Health Access Data Assistance Center (SHADAC). (2015, April). Table 6: Health insurance markets. *Idaho State Profile*. Prepared by SHADAC and NORC at the University of Chicago for the Center for Medicare and Medicaid Innovation.

³⁴ SHADAC. (2015, April). Table 5: Health insurance markets. *Idaho State Profile*. Prepared by SHADAC and NORC at the University of Chicago for the Center for Medicare and Medicaid Innovation.

³⁵ The Henry J. Kaiser Family Foundation. (2016). State Health Facts, Health Insurance and Managed Care Indicators. Retrieved July 26, 2016, from <http://kff.org/state-category/health-insurance-managed-care/insurance-market-competitiveness>.

D.3.2 Governance and program administration

The IDHW is the recipient of the SIM Model Test award. Within IDHW, the SIM team in the Office of Healthcare Policy Initiatives oversees day-to-day operations and management. There is also one SIM staff person based in the Bureau of Rural Health and Primary Care who is project manager for the RCs, telehealth, CHWs, and CHEMS. There are fewer than 10 IDHW SIM staff members; however, they are supported by contractors that assist with PCMH transformation, HIE, and data analytics. A number of state officials indicated they are using more resources than provided by the SIM award. Some mentioned that, in hindsight, they would have budgeted for more project staffing.

The IHC guides overall SIM implementation. Established by Executive Order in February 2014, the IHC comprises key stakeholders from both the private and public sectors and is co-chaired by a representative of each sector. The coalition meets regularly to discuss issues related to SIM implementation and provides recommendations to IDHW. The IHC serves a critical role, providing the structure through which the state can achieve SIM goals through consensus rather than government mandates. Stakeholders saw this approach of building consensus through the coalition as an integral component for SIM Initiative success.

The IHC's efforts are supported by the following advisory groups and work groups that cover a range of topic areas and regularly meet to provide implementation recommendations: the Behavioral Health Integration Workgroup; the Clinical Quality Measures Workgroup; the Community Health Workers Advisory Group; the CHEMS Workgroup; the Health Information Technology Workgroup; the IMHC Workgroup; the Multi-Payer Workgroup; the Population Health Workgroup; and the Telehealth Council.

Most stakeholders, including payers, providers, and consumer advocates, are engaged with SIM staff through their participation in the meetings of the IHC and its related workgroups (although self-funded employers and oral health representatives wish they had been invited to participate earlier in the process, as noted). Overall, stakeholders indicated the state is very responsive to their needs, has developed a robust plan for PCMH transformation, and has managed the IHC meetings and the implementation process well, given the large number of stakeholders involved.

D.3.3 Stakeholder participation

Stakeholder participation in SIM implementation builds on the state's previous PCMH initiatives. Through these initiatives, state leaders in both the public and private sectors built a cadre of key stakeholders that were eager—and prepared—to engage in SIM planning and implementation. Even at that point, stakeholders representing primary care, specialty care, hospitals, and others were heavily engaged in planning delivery system reforms. State leadership used Idaho's Model Design award as an opportunity to invite more stakeholders into its delivery system reform efforts. The Model Design phase of Idaho's SIM Initiative featured robust

engagement of a wide range of stakeholders, to ensure the plan had the backing of the relevant stakeholders needed to produce change. This robust stakeholder engagement has continued into the Model Test phase, with IHC representatives spanning the IDHW, PHDs, Department of Insurance, providers, hospitals, county EMS agencies, commercial payers, consumer advocates, and IHDE. While Native American tribes are not explicitly represented on the Idaho Healthcare Coalition, Indian Health Services (IHS) providers are eligible to participate in SIM-sponsored PCMH conversion. In fact, the Coeur d'Alene tribe's health center, which is a designated community health center, and one IHS provider are in the first cohort of practices participating in the SIM Initiative.

The PCMH is the core of the SIM Initiative. Thus, stakeholders uniformly identified payers and providers as the most critical stakeholders to engage. Most also reported that Medicaid had already implemented payment reforms, but that engaging commercial payers was proving more challenging. As discussed under *Section D.3.4*, payers support SIM goals but would prefer to continue to set their own direction in payment reform. State officials are working to address these concerns by offering more flexibility in payment models. Despite these challenges, it is notable that many interviewees said they felt payer engagement was succeeding because “all payers are willing to come together and consider value-based payment models.”

Some stakeholders said they were initially concerned that it would be difficult to engage sufficient providers in PCMH transformation, because during early SIM implementation some providers had expressed concern about the cost of transformation. This concern about provider engagement was alleviated when over 100 providers applied to join the first cohort for PCMH transformation—although some stakeholders remain concerned that it might be difficult to fill the third cohort. Additionally, providers are actively engaged in the RCs, not only as members but also because each RC is co-chaired by physicians. One interviewee noted that the national movement toward payment reform promoted by CMS was crucial to provider engagement.

Two stakeholder groups not initially included in SIM planning, as noted, were self-funded employers and oral health representatives. Both groups, upon learning of the SIM Initiative, asked to participate in SIM planning work and implementation. The SIM team and IHC have since invited these stakeholders to participate in the relevant groups, but representatives of self-funded employers are still concerned that not enough is being done to engage this large group. Oral health representatives said they are satisfied with their current level of involvement, but wish oral health activities had been allocated some SIM funding.

D.3.4 Delivery systems and payment reforms

Idaho's delivery system and payment reforms are focused on the state's primary care system—in particular, spreading the PCMH model statewide and helping PCMHs function as part of an organized medical/health neighborhood. Idaho's SIM Initiative is supporting practices' efforts to become PCMHs, as well as RCs' efforts to define the local medical/health

neighborhood and foster efficient connections between PCPs and the neighborhood. Idaho is also developing VBP reforms to support and sustain its PCMH model.

Patient-centered medical homes. SIM funds will be used to provide training and TA to the 165 participating primary care practices (divided into three cohorts over 3 years, as described above). One of the primary goals of PCMHs is to improve care coordination through the use of EHRs and health data connections between PCMHs and the broader medical/health neighborhood. In addition, PCMHs aim to help patients play a more active role in managing their own health, help patients get the care they need, create personalized health plans, make it easier for patients to reach their doctors, and provide coaching to help patients reach their health goals.

At the time of the 2016 site visit, stakeholders reported that Idaho was implementing its delivery system reforms as envisioned. The state had engaged a contractor (Briljent, LLC and its subcontractors Health Management Associates and Myers & Stauffer) that will provide TA to the 165 practices. The contractor had already begun providing TA to the first cohort of 55 practices, which represent the full range of providers who provide primary care in Idaho. Stakeholders reported that over 100 practices had applied to join this first cohort, making state officials optimistic they would ultimately achieve the goal of transforming 165 practices into PCMHs.

The contractor also will distribute the lump sum payments selected practices will receive for achieving specified milestones. Most of the first cohort's 55 practices have each already received a lump sum payment of \$10,000 for executing a memorandum of understanding delineating their commitment to the TA, completing the clinic agreement with Briljent, and finalizing a transformation plan. The practices are also eligible, as noted, for reimbursement of the cost of accreditation (or reaccreditation); a free, SIM-subsidized connection to the IHDE; and a \$2,500 payment for becoming a virtual PCMH. These payments are in addition to the ongoing payments practices may receive from Medicaid and other payers.

To become a virtual PCMH, as noted, a PCP that has met PCMH qualifications must embed one of three modules into its practice: telehealth, community paramedicine, or CHWs. Stakeholders believe that integrating any of these three approaches into a PCMH will enable it to extend its reach into rural areas. Idaho stakeholders reported that they were operationalizing these modules—preparing the CHWs and community paramedic personnel to fulfill their new role in delivering primary care, and developing strategies to integrate these personnel and telehealth into the PCMH team.

Regional Health Collaboratives. Idaho has undertaken a second delivery system reform intended to better organize the delivery system around primary care and better link the medical and social services systems—creating the seven RCs to support the PCMHs, as described earlier. Each of the state's seven regional PHDs is allocated one RC.

At the time of the 2016 site visit, the IDHW had signed contracts with each of the Public Health Districts to support the RCs. Further, each district had established an executive leadership group and convened an RC stakeholder advisory group to identify local priorities and plan the work. Under its contract, each district receives funding for three staff—a SIM manager to oversee RC activities, a quality improvement/quality assurance specialist to support practices seeking to become PCMHs, and an administrative assistant to support the work. The executive leadership group consists of the district’s director, SIM manager, and chair and co-chair of the RC advisory group (both of whom are physician champions the IHC selected).

Many stakeholders interviewed saw potential in the RCs. Stakeholders also, however, expressed some concerns about the RCs ability to fulfill that potential. Some were concerned that the RC advisory groups did not have sufficient access to data to enable them to make data-driven decisions on priorities and strategies. In addition, although most expressed the belief that physician leadership of the RC advisory groups was critical to success, some were concerned that other key players—especially those that might ultimately sustain the work of the RCs—did not have sufficient representation. Others reported that some RCs were struggling to find consumer representatives to serve on the advisory groups. SIM leadership has identified strategies to address these concerns. For example, IDHW procured a statewide data and analytics contractor to provide the RCs with local data (among other tasks). Also, the Division of Public Health is working, through a different system, to provide the RCs with public health data, such as mortality data for their area.

Payment reform. The SIM Initiative had originally envisioned that all payers would support ongoing PCMH costs through PMPM payments (in addition to the payments practices receive for delivering services). Although practice transformation and RC creation are mostly proceeding on schedule, Idaho has encountered challenges in payment reform. The Medicaid agency has forged ahead on payment—modifying its existing primary care case management program (Healthy Connections), effective February 2016, to incorporate those practices that had participated in the Health Home pilot and align the payment structure with that envisioned in the SIM Initiative. Specifically, Idaho Medicaid has implemented a four-tier payment model. Providers who previously participated in Healthy Connections can continue to do so in Tier 1 or 2. Those practices with more extensive PCMH capabilities—including having a dedicated care coordinator, a connection to the IHDE, or a behavioral health integration strategy in place—are qualified to join Tier 3 or 4. Each tier is paid at a progressively higher rate. Almost all stakeholders interviewed during the site visit praised the agency’s leadership in this area.

Commercial payers, however, do not wish to adopt a similar payment model. Payers expressed support for the goals of transforming the delivery system and moving to VBP, but not the PMPM payment model. Almost all interviewees identified commercial payers as the most difficult group to engage in SIM implementation. Commercial payers reported that they were brought into SIM planning late (compared to other stakeholders) and did not have a major

influence on the design. Further, they reported they were already shifting a large portion of their contracted providers to VBP models, including total cost of care and other risk-sharing arrangements that tie payment to performance on quality metrics. Payers said they prefer these models because they (1) include a comprehensive set of services, (2) can be administered at the network level, (3) enable payers to build on the arrangements they already had in place with providers, and (4) enable them to differentiate themselves in the market. During Award Year 1, Idaho’s SIM leadership gathered information about the alternative payment models used by commercial payers, and ultimately modified their payment reform goal to “shifting 80 percent of all payers’ payments to alternatives to fee-for-service (FFS) arrangements instead of targeting 80 percent of the state’s population to the PCMH model.”³⁶

Several different stakeholders expressed concern over reaching even this new goal. As of 2013, Medicaid only covered about 11 percent of the Idaho population. So, while having Medicaid implement VBP reform is a big step forward, reaching the 80 percent goal would still require substantial participation from every other sector. As of May 2016, Medicare (which accounted for roughly 15 percent of the population in 2013)³⁷ and self-funded employers (which insured roughly 30 percent of the population in 2013)³⁸ were still not participating in SIM payment reform—making the goal of reaching 80 percent of all payers’ payments a major challenge.

Funding and sustainability. The other most frequently expressed challenges concern finances. The Idaho SIM award, as noted, supports fewer than 10 staff directly within IDHW. Many people doing the work at the local level are volunteers, and stakeholders expressed concern about burn-out for them. One interviewee expressed the view that, without a financial lever (such as the ability to pay for services), the RCs would be unable to produce change. Many also were concerned about sustainability after SIM funding ends. State officials and others emphasized that the RC model is new, and that each RC might develop in a different way and ultimately secure funding from different sources (e.g., payers or hospitals) or different payment models (e.g., shared savings). A couple of stakeholders said they believe an RC might develop into an accountable care organization or be absorbed into some other entity that could take on risk. These stakeholders felt that, at this early stage of RC development, it was important that each have the flexibility to develop its own strategic plan—including plans for sustainability.

D.3.5 Health information technology and data infrastructure

Idaho’s SIM Initiative envisions expanding and strengthening health IT and HIE to (1) enable providers to better coordinate the care delivered to individual patients and (2) produce

³⁶ Idaho Department of Health & Welfare. (2016, February 2). *Idaho Healthcare Coalition, quarterly progress report, SFY 2016, Q2*. Retrieved September 14, 2016, from <http://ship.idaho.gov/Portals/93/Documents/IHC/2016%20IHC/SFY20162QtrlReportFINAL.pdf?ver=2016-04-12-165643-147>

³⁷ SHADAC, Table 6: Health Insurance Markets. See note 1.

³⁸ SHADAC, Table 5: Health Insurance Markets. See note 2.

quality and outcomes measures for use in assessing and improving performance at the PCMH, regional, and statewide levels. The primary players in this effort are the IHDE and a statewide data analytics contractor (HealthTech Solutions) the state recently secured.

The IHDE was created in 2009 as a 501(c)(6) organization (a tax-exempt nonprofit designation for business leagues and other similar organizations). As described earlier, many providers (including all members of the first practice transformation cohort) have EHRs, but most are not participating in the IHDE or have chosen to pay to view data about their patients but not add their own data. Stakeholders reported that providers and payers saw little value in joining the IHDE, because it is costly to connect and often does not provide additional information about patients. Additionally, both providers and payers commented that the IHDE does not have the analytic capacity to provide practical and actionable data that could assist with coordinating the care of individual patients or specific populations. Thus, despite the relatively high prevalence of EHRs in PCPs in Idaho, most still receive follow-up specialist or hospital visit information via fax. These after-visit summaries, PCPs reported, are often dozens of pages of mostly irrelevant information, with only a small amount of important data that are hard to find.

The perceived limited usefulness of IHDE data was especially true of practices associated with large networks, which already supported exchange of data on the services patients obtained within their network. Of course, one of the reasons the IHDE contained little additional information was that so few providers were contributing their own data. Another factor is that many Idahoans obtain services from providers in Salt Lake City (Utah) or Spokane (Washington), which would not be entered into Idaho's IHDE by definition. As a result, practices often do not know when their patients obtain services from providers outside their network, including admission to a hospital outside the network. The SIM Initiative seeks to address this challenge through two strategies. First, supporting the Medicaid plan in which joining the two highest payment tiers requires a PCMH to connect to the IHDE (Tier 3) and to exchange data through the IHDE (Tier 4). Second, Idaho is paying the IHDE connection fees for practices participating in the PCMH transformation, as well as offering TA in the connection process and for incorporating routine use of the data into their workflows.

In addition, Idaho is working to engage other types of providers (e.g., hospitals) and more payers in the IHDE. For example, the IHDE is developing use cases to show how the IHDE can meet provider and payer goals. Most stakeholders were optimistic that these changes will enable the IHDE to improve the value of its offerings and, ultimately, engage more providers and payers. Others, however, were not optimistic that the benefits can be improved enough to justify the cost of joining the IHDE; one payer in particular noted that the lack of a population health analytics component was a factor for its choice not to participate.

The statewide health analytics contractor is primarily responsible for producing the quality and outcomes measures that will be used to assess and improve quality and outcomes. This contractor is just starting its work, but it will face challenges in securing the data needed to

produce the requisite measures, as no existing source includes data from all payers and providers. Current plans call for the use of Medicaid claims data, reports from commercial payers, and data from the providers participating in the PCMH transformation—a role these stakeholders have all agreed to play.

Idaho has developed an Initial Performance Measures Catalog that includes measures the IHC selected via consensus. During the year preceding the 2016 site visit, the IHC’s Health Information Technology and Clinical Quality Measures work groups have been working together to reach consensus on measure specifications, including standardized definitions of each measure’s numerator, denominator, and data source(s). This effort has been challenging, as providers in Idaho use many different EHRs that each collect and store data differently. Some stakeholders expressed concern about the ambitious number of measures included in the catalogue. Others were worried that the measures were chosen for their clinical importance—but that other more results-focused measures, such as ones that are better at capturing patient outcomes and possible cost savings, might be needed to demonstrate the value of the PCMHs and RCs to the legislature and potential payers. Idaho plans to revise and refine the quality measures to better align with national metrics, and drop those it deems are no longer relevant.

D.3.6 Workforce development

Idaho is a rural state with severe health care workforce shortages. One state official reported that about 97 percent of Idaho is a designated Health Professional Shortage Area for primary care, and 100 percent of the state is a shortage area for behavioral health. Workforce development plans, which were created with the guidance of the Idaho Health Professions Education Council, center on extending the reach of the state’s current primary care workforce. The move to the PCMH model, which is a team approach to delivering primary care in which all members of the team ‘work to the top of their license,’ will itself extend current primary care resources. Idaho’s plans, as noted, also call for improving access in rural areas by creating virtual PCMHs—which will incorporate telehealth, CHWs, and/or CHEMS into the PCMH team.

As discussed earlier, Idaho plans to transform 165 practices into PCMHs. At the time of the 2016 site visit, the first 55-practice cohort was receiving a package of TA tailored to their needs and priorities. This package includes learning collaborative meetings, webinars, and individual coaching. Stakeholders reported that the first learning collaborative meeting in March 2016 was well received by participating providers.

Stakeholders said they believed telehealth will be especially useful for improving access to behavioral health services through PCMHs. At the time of the 2016 site visit, Idaho was designing its telehealth expansion, which some described as primarily consultation. The state was also close to issuing a request for quote to secure a contractor to provide telehealth training to PCMHs seeking to add telehealth to their practices.

The state's vision for the CHWs and CHEMS is that they will be trained workers who can serve a variety of functions that augment the PCMH, including conducting home visits and helping patients access community resources. The specifics of these models, including how they will be integrated into the PCMH and how they will be paid, is still unfolding. State officials reported that the models are progressing as planned, and a broad range of stakeholders expressed support for the concepts.

State officials described the CHWs as working with a group of patients from a small number of clinics. The CHWs will follow the patients in the community and report back to the PCMH to manage their care. The CHWs will also interact with patients at the clinics with a particular focus on helping them address nonmedical issues that impact health, such as food and housing. At the time of the 2016 site visit, the IHC had selected a curriculum, the IDHW had contracted with Idaho State University to deliver it, and the University was in the midst of recruiting faculty. Idaho plans to train up to 200 CHWs by the end of Award Year 4—with the SIM Initiative funding curriculum development, but not the training itself.

The state described CHEMS staff as having a similar role to that of CHWs. CHEMS will conduct home visits and help patients connect with resources in the community during the EMS staffs' down time. At the time of the 2016 site visit, state officials—working as part of the CHEMS subcommittee of the IHC—had created outreach tools, designed measures, and implemented a curriculum. Idaho plans to train 52 CHEMS staff by the end of Award Year 4—with both curriculum development and training funded by the SIM Initiative.

Although stakeholders were supportive of these new models, several also expressed concerns, mostly about sustainability. They expressed differing visions of who would employ and pay for the CHWs and CHEMS workers after the end of the SIM Initiative—mentioning some combination of PCPs, hospitals, and payers as possibilities for both roles. But some were concerned that these players might not ultimately choose to fund the workers. One stakeholder said payers were interested in paying for outcomes (not action), and that this made it difficult to engage them earlier in the process of building the virtual PCMH model. This in turn presented a challenge to proving the value of the model, as the payers were the sources of utilization and cost data needed to do that.

Another challenge stakeholders mentioned is engaging providers interested in integrating these workers into their practice. At the time of the 2016 site visit, the practice transformation work was just starting. These practices, which will be the target for this part of the SIM Initiative, are busy—perhaps too busy to be ready to engage in this part of SIM implementation. As one stakeholder summed up the current status, “We’re just trying to focus right now on getting people trained and getting the infrastructure built so we can have those two programs solid in the state.”

D.3.7 Population health

The Idaho SIM Initiative incorporates population health elements and will help support existing population health initiatives in the state. For the SIM Initiative, IDHW's Division of Public Health is primarily focusing on assisting the RCs in their work—which includes supporting practices' transformation to the PCMH model and integration with the broader medical/health neighborhood. To guide this work, the IHC established a Population Health Workgroup, which the Administrator of the Division of Public Health leads, and which has broad membership (including representatives of the PHDs). Division staff also inform discussions of clinical health measures and are responsible for implementing the virtual PCMHs.

The SIM Initiative also supports IDHW's efforts to implement the existing statewide health improvement plan. The 5-year plan, *Get Healthy Idaho: Measuring and Improving Population Health*,³⁹ which was published in July 2015 and initiated prior to the SIM Initiative, focuses on four health priorities: (1) access to health care, (2) diabetes, (3) tobacco, and (4) obesity. The plan was developed as part of the Division of Public Health's accreditation process, and its focus areas are based on a statewide health needs assessment. To meet the SIM Initiative requirement for a population health improvement plan, the state decided to combine the work already initiated through *Get Healthy Idaho* with the SIM Initiative. The leading health indicators identified in *Get Healthy Idaho* provided the framework for the primary data used in the statewide needs assessment, and align with SIM efforts to improve health care and outcomes and reduce costs. Further, both efforts recognize that the lack of patient-centered care in the state is a common underlying issue that contributes to poor health outcomes.

IDHW is currently working to operationalize the population health plan within the overall SIM Operational Plan, which involves defining the scope of population health and ensuring the medical/health neighborhood includes social and community services. A significant portion of the Division of Public Health's SIM-related efforts are directed toward providing guidance and resources to the RCs in their work to support practices. Additionally, SIM efforts to promote access to care through the CHWs and CHEMS incorporate aspects of population health, as they are designed to provide health education/outreach and promote patient self-management for individuals with chronic diseases in remote rural areas.

Most stakeholders indicated that the SIM population health efforts hold promise. As noted in the SIM Operational Plan, the integration of the PCMH model into the medical/health neighborhood is a significant aspect of the state's population health improvement strategy, as non-health care sector organizations provide critical social services that can support health improvement. Many also cited the RC model, in particular, as having strong potential for success

³⁹ Idaho Department of Health & Welfare, Division of Public Health. (2014, April). *Get Healthy Idaho: Measuring and Improving Population Health*. Retrieved from [http://www.healthandwelfare.idaho.gov/Portals/0/Health/Get%20Healthy%20Idaho%20%20Measuring%20and%20Improving%20Population%20Health%20%20%20April%202015%20\(2\).pdf](http://www.healthandwelfare.idaho.gov/Portals/0/Health/Get%20Healthy%20Idaho%20%20Measuring%20and%20Improving%20Population%20Health%20%20%20April%202015%20(2).pdf)

in support of the SIM Initiative. The existing PHD infrastructure within the state offered a robust model for building the framework of the RCs and engaging the expertise of local stakeholders. State officials also indicated that a key strength of the RC structure is that it combines the expertise of public health and primary care, and helps focus overall SIM efforts on health promotion rather than disease management. At the time of the 2016 site visit, the RCs were already operating, and regularly meeting to begin their planning efforts to support practices' transformation efforts and integration with the overall medical/health neighborhood.

D.3.8 Technical assistance and other support resources

State officials and other stakeholders uniformly expressed appreciation of the SIM Initiative opportunity as a whole. They said they believed it would enable them to reach their goal to create and sustain statewide access to PCMHs that function as part of an organized medical/health neighborhood. They reported that they had a good working relationship with the CMMI SIM team, and were satisfied with the TA and other support provided to them. They were particularly pleased with the assistance given on engaging self-funded employers. Some mentioned that the SIM Initiative approval process was sometimes slow, which impeded SIM implementation. Some said they would appreciate more flexibility in shifting SIM funds to meet unfolding needs. And some reported that, although they appreciated the completeness of the information provided by the contractors in response to requests, they would prefer to receive more summary information. Specifically, they would like the TA contractors to provide an analysis of the available information that drew out for stakeholders the key information and options needed to make decisions.

D.3.9 Progress, challenges, and lessons

Overall, Idaho is progressing with SIM implementation as planned. However, two emerging challenges could develop into major obstacles: (1) securing commercial payer engagement in payment reform and (2) increasing the number of providers exchanging information via the IHDE. State officials and the IHC recognize these challenges and are working to address them. However, some stakeholders expressed uncertainty about whether the strategies being developed will fully address these challenges. Other lessons also have emerged from Idaho's early implementation experience, with stakeholders most frequently mentioning the following:

Early involvement of experts knowledgeable about potential data sources and existing analysis capacity will be important in streamlining specification of performance measures. A number of key stakeholders felt that the number of measures in the catalogue might be overwhelming to providers and that, early on, it might have been better to focus on fully defining the specifications for a handful of measures that are both clinically relevant and technically feasible to produce. Stakeholders explained that many of the practices engaged in transformation had never generated quality metrics before, and will need sufficient support to not only produce the measures but also make them useful. The IHC's Health Information Technology and Clinical

Quality Measures work groups are now working together to develop consensus on measure specifications.

Addressing behavioral health and primary care integration will be important to achieving State Innovation Model aims. Behavioral health integration was not a major focus of Idaho’s SIM Initiative. However, stakeholders reported a growing consensus that identifying and addressing patients’ behavioral health needs is critical to achieving the aims of improving quality and patient experience, as well as reducing costs. Some emphasized that integration will need to go both ways—integration of behavioral health into PCMHs and of primary care into behavioral health. The IHC established the Behavioral Health Integration work group to develop recommendations in this area.

State Innovation Model implementation will depend on many stakeholders’ willingness to volunteer their time and resources. Almost all stakeholders in both the private and public sectors mentioned that they are devoting resources to SIM implementation beyond those provided by the SIM award. Many said they always knew their state’s SIM Initiative was, to an extent, going to depend on volunteers. Some mentioned that the cuts made to bring the budget down to the amount offered by the federal government (two-thirds of the requested amount) made implementation even more reliant on volunteers. Others said the state had simply underestimated the resources needed for implementation. However, all agreed they saw the SIM Initiative as so important they were willing to volunteer resources to the effort.

D.4 Statewide Changes

D.4.1 Health care expenditures

State officials and other stakeholders alike agreed that health care expenditures are too high and growing to unsustainable levels, and that something has to be done to rein in spending. As one doctor put it, “this can’t continue...you can’t spend approaching 20 percent of our GDP on health care.”

The primary component of Idaho’s SIM Initiative that will impact health care expenditures is the PCMH model. PCMHs will be supported by increased health IT infrastructure and IHDE connectivity, assistance from RCs, and VBP reform. With these systems in place, Idaho expects to save \$89 million by 2019, through reductions in ER utilization for nonemergency episodes, inpatient admissions, inpatient readmissions, and admissions to the neonatal intensive care unit; and through increases in the generic fill rate for prescribed pharmaceuticals.

The SIM team intends to create an actuarially certified projection of costs that would have been incurred during Award Years 2-4 if the model had not been implemented, and compare that to actual costs in order to measure savings. The SIM team also plans to measure the “total population-based PMPM index,” defined as the total cost of care divided by the population

risk score, as well as a SIM return on investment, which is the estimated savings divided by the cost during Award Years 2-4. Some stakeholders are optimistic that expenditures will be reined in with the PCMH model and supporting strategies, but expenditures are not the big issue on most stakeholders' minds. They sounded more concerned that the overall system is broken and needs to be repaired, and that cost savings should occur as a result.

D.4.2 Health care utilization

State officials and other stakeholders see unnecessary or preventable use of the ER and hospitalizations as one of the drivers of out-of-control health care expenditures. They see an opportunity to move more care to PCPs or other forms of lower-cost care to reduce utilization in higher-cost settings—a goal the PCMH model with coordinated care is specifically aimed at achieving. PCMHs, combined with VBPs, give PCPs the incentives and tools needed to proactively manage their patients' health. These tools include EHRs with data from hospitals and specialists, and advanced analytics to identify patient needs. Providers and other stakeholders are optimistic that the PCMH model will reduce ER utilization for nonemergency episodes, inpatient admissions and readmissions, and admission to the neo-natal intensive care unit, and will calculate relevant quality measures at the provider and even regional and state levels to evaluate the success of the model. These utilization-related measures include asthma ER visits, acute care hospitalization (risk-adjusted), readmission rate within 30 days, and avoidable emergency care without hospitalization (risk-adjusted).

D.4.3 Care coordination

Physicians in both interview and focus group settings said they felt that care coordination was lacking and that, in particular, doctors knew they could do a better job of communicating with one another. According to their reports, most practices do not have closed-loop referrals, and have no formal mechanism in place to get information back from the specialist. Referrals to ancillary professionals (e.g., dietitians, dentists, and social workers) seem particularly problematic, in that some providers do not even have an informal referral network for these types of services—let alone formal protocols to make and follow up on a referral to these settings. Physicians also discussed improving care coordination within a practice—in particular, that providers need to put more emphasis on preventive care, conduct screenings (e.g., depression screening) that will help identify treatment needs earlier, and implement workflows that will enable them to identify patients due for certain services, such as diabetic foot exams. While most physicians sounded eager to improve care coordination activities, they said they felt too busy to focus on that aspect of care. One physician, however, did not see a benefit to care coordination and referred to it as having to “babysit patients.”

Some Medicaid beneficiaries participating in focus groups received primary care at a major medical group in Idaho that already has a big emphasis on care coordination. Patients in that system said (1) their primary care doctor always knew when they were in the hospital, as well as what happened, and followed up as necessary; (2) referrals and care from specialist

providers were well coordinated; and (3) through the EHR, the primary care physician could see what care had been provided. Patients outside that system generally felt care coordination was much more lacking. For example, one patient who needed a kidney transplant but was currently ineligible due to her weight said that the doctor treating her for diabetes could not tell her how much weight precisely she needed to lose to be eligible, and referred her to a diabetes center. That diabetes center also could not tell her how much weight to lose, and to date she has not been able to get the right referral to help with this question.

Idaho is addressing the issue of poor care coordination directly with the PCMH transformation, which should improve the delivery of services within a practice and increase early identification of issues or conditions. The PCMH model emphasizes care coordination and allows physicians to focus their time on clinical care, while other staff (e.g., nurses or care coordinators) provide care within the appropriate scope of their practice. Idaho is helping practices transform to the PCMH model and improve care coordination through a contractor providing direct support—which includes a 3-year training program with on-site learning collaboratives to review topics from team-based care to care coordination, topic-specific regional video conferences, monthly coaching, and tailored transformation plans. Practices are also receiving assistance to develop registry functionality and referral tracking. In addition to promoting the PCMH model, Idaho is establishing three support structures to aid practices in being more effective care coordinators: (1) the IHDE to facilitate the sharing of patient data, (2) RCs to establish the medical/health neighborhood, and (3) VBPs to help providers cover costs of additional care coordination activities.

Stakeholders stated that successful care coordination requires protocols for managing care both within and across practices. According to one state official, successful care coordination in Idaho would entail patients being able to go from one physician to another, regardless of the setting, and have their records easily available to each new physician. At the clinician level, there should be reduced duplication of work, such as imaging and testing, so all doctors can see the results of tests other providers performed. Further, PCMHs should have established protocols for screening and identifying patient needs, so they can be treated before progressing to a more serious state. Care coordination should also involve high-quality transitional care from the hospital, including a phone call within a few days of discharge and a follow-up visit within 2 weeks, without the patient having to initiate the visit. In addition, while behavioral health was not an explicit goal in Idaho's SIM Initiative, several state officials and other stakeholders said that they would like to see behavioral health better integrated into primary care, and that the IHC has established a behavioral health work group to help address some of the issues unique to this area.

To assess the success of care coordination–related initiatives, Idaho plans to track several measures related to each component of care coordination improvement.⁴⁰

- Establishing PCMHs (e.g., number of PCMHs, number receiving technical support)
- Health IT and Information Exchange (e.g., number of patients with an EHR, number of practices and hospitals connected to IHDE)
- RCs (e.g., number of RCs, number of PCMHs getting RC assistance)
- VBPs (e.g., count of providers under contract for non–volume-based reimbursements, percentage of payments made in non-FFS arrangements)

State officials and other stakeholders expressed optimism that the SIM Initiative will improve care coordination overall, particularly because this is one of the main areas of focus in the PCMH model of care, and the state is providing a high level of support to practices to move to this model. However, some of the supporting mechanisms (health IT, RCs, and VBPs) face challenges. As detailed in **Section D.3**, the health IT progress has been slow and payers are reluctant to join the IHDE. At the time of the 2016 site visit, RCs had made satisfactory progress, but were still working to define their role and faced a lack of data needed to make decisions on priorities and strategies. Finally, while commercial payers were moving to VBPs, they were doing so typically in a manner different from that of Medicaid; and further, without Medicare and self-funded employers participating, stakeholders said there may not be adequate long-term funding for care coordination activities.

D.4.4 Quality of care

Multiple providers mentioned that Idaho ranks poorly on national health measures and that they would like to improve the quality of care in the state. Particular concern centered on the lack of providers in rural areas that contributes to these gaps. The state is implementing virtual PCMHs to address the rural health care shortage, and expressed the hope that this novel delivery model will improve access and quality of care. Statewide, the SIM Initiative will be establishing protocols to help identify gaps in care at the patient level and to provide better communication within the medical/health neighborhood about a patient’s care plan and records. Eventually, shared savings will be implemented in Medicaid’s payment structure as well. As a result of more care coordination activities and enhanced health IT, stakeholders expressed their belief that quality of care will improve. Designated personnel will track patients to ensure their care adheres to evidence-based clinical practice, and such personnel should have all the patient-level data necessary to do so.

The SIM team has identified numerous quality measures they will track, and they will be setting targets for each measure in 2016. Quality measures will include areas such as screening for clinical depression; tobacco cessation intervention; low birth-weight infants; adherence to

⁴⁰ These measures are from the SIM Operational Plan; however, the SIM team is in the process of refining and revising the list of quality measures that will be calculated.

antipsychotics for individuals with psychotic diagnoses; weight assessment and counseling; comprehensive diabetes care; childhood immunization; and blood pressure control for individuals diagnosed with hypertension. Utilization measures listed in *Section D.4.2*, will also be used to measure quality.

D.4.5 Population health

Population health had been a focus of the Division of Public Health before the SIM Initiative award to Idaho. The Division had been going through an accreditation process, part of which required development of a statewide needs assessment and statewide health improvement plan. When the SIM award was granted, the Division of Public Health decided to meld the existing accreditation process with the SIM Initiative. The issues that rose to the top in the needs assessment that had already been completed (e.g., exercise, suicide, tobacco use) were related to the three health conditions the SIM Initiative identified (diabetes, tobacco use, and obesity). The one priority that emerged strongly from the needs assessment but did not fit well within these three ‘SIM conditions’ was access to care. As a result, the SIM population health plan addresses four priorities: diabetes, tobacco use, obesity, and access to care.

IHC has established a Population Health work group, led by the Administrator of the Division of Public Health, which is currently working through the specifics of how to incorporate the population health plan into all SIM activity. Because much of the previous IHC work has been more clinical, the work group is also working toward a common understanding of what ‘population health’ means to Idaho. Stakeholders believe the RCs are going to be the primary means of impacting population health, and they are structured to enable this coordination—based in the PHDs and with formal links (contracts and staff) to those districts. The Division of Public Health is also seeking a contractor to provide data to the RCs to support their decision-making and improvement efforts—to be separate from the data analytics contractor, and tasked specifically with developing regional data from public health data sources.

The success of population health will be determined by improvements in the four priority areas: diabetes, tobacco use, obesity, and access to care. The population health improvement plan, *Get Healthy Idaho*, has established performance measures in these areas that are already tracked at the state level by the Division of Public Health. Whereas most stakeholders say it is too early to tell if the SIM Initiative will impact population health, most are optimistic there will be some positive effect.

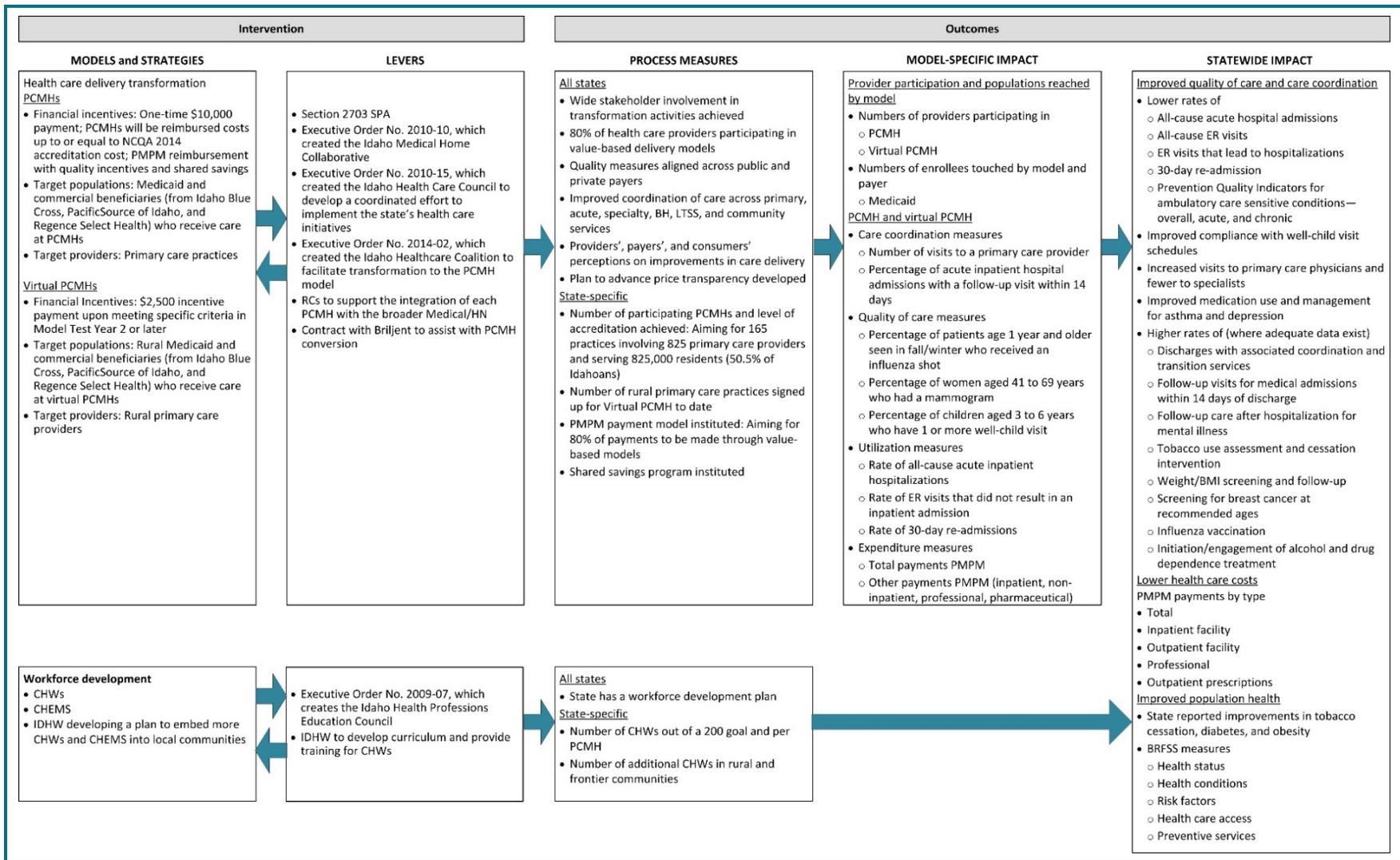
D.5 Overall Idaho Summary

Over the course of Award Years 2-4, Idaho aims to transform its health care delivery system through implementation of the PCMH model and shifting from an FFS model to alternative VBP methods. As the core component of the SIM Initiative in the state is implementation of the PCMH model, both providers and payers play a very significant role in the success of the state’s efforts. Stakeholders indicated that the conversion of practices to the

PCMH model has a strong potential for success, as evidenced by robust provider interest and the significant number of practices that applied to be part of the first cohort of participating clinics. In terms of payers, Medicaid has already assumed a leading role in moving payment reform efforts forward through the SIM Initiative. Although commercial payer engagement has been somewhat challenging, stakeholders noted as encouraging that all payers are willing to consider implementing VBP models.

Based on the information gathered from stakeholders during the 2016 site visit, overall progress on the initial stages of PCMH transformation is consistent with the proposed timeline. Yet challenges remain, such as commercial payer engagement and IHDE connectivity. Further, there is the broader issue of sustainability, particularly in terms of some of SIM's supporting elements (e.g., the RCs), and the overall financial stability of the PCMH model beyond Award Year 4. However, stakeholders frequently cited the broad group of stakeholders that are fully engaged and committed to working together toward achieving the SIM Initiative's goals as a highly promising factor in SIM success.

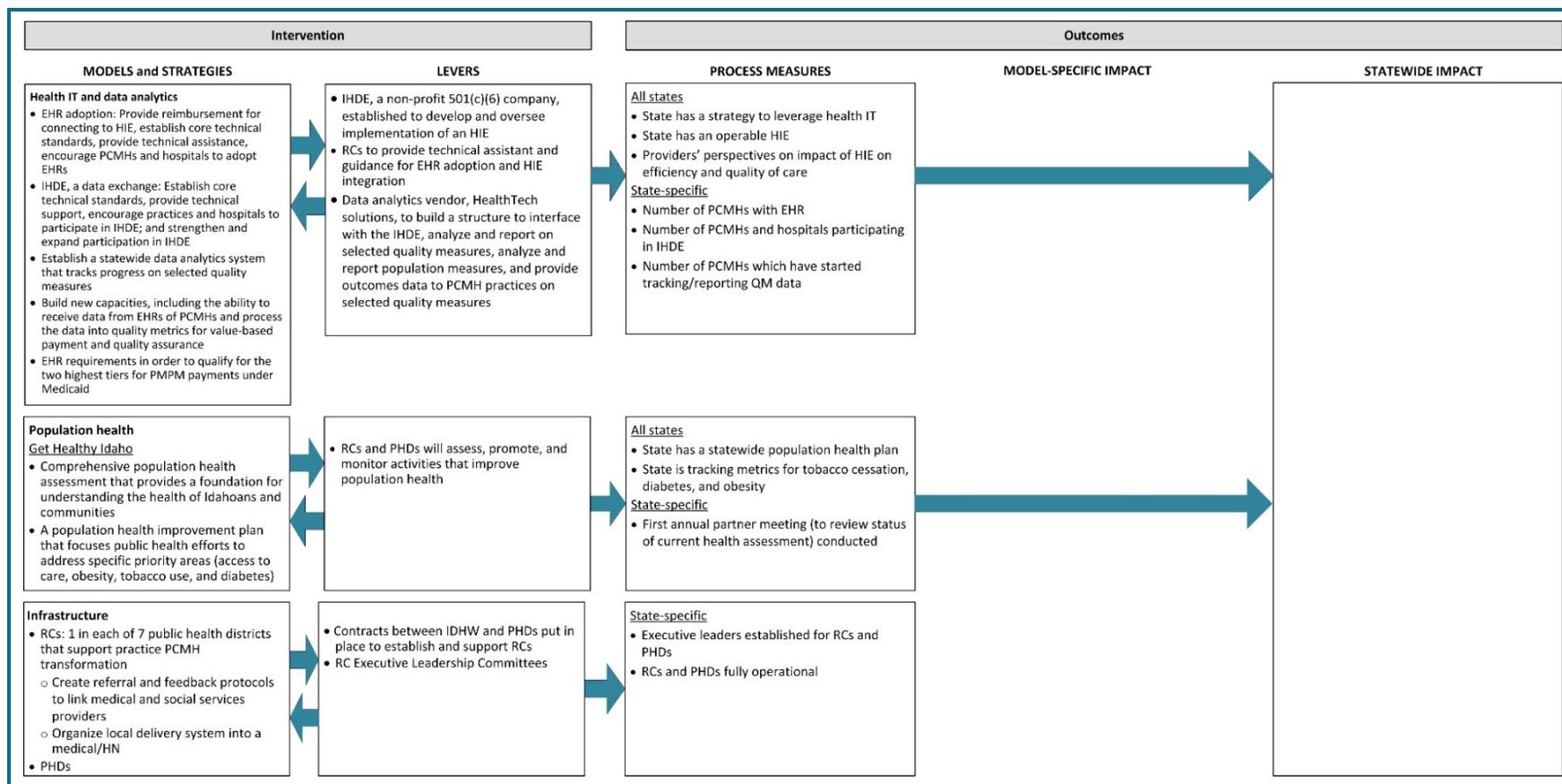
Figure D-1. Logic model for Idaho's State Innovation Model activities



(continued)

Figure D-1. Logic model for Idaho’s State Innovation Model activities (continued)

D-23



BH = behavioral health; BMI = body mass index; BRFSS = Behavioral Risk Factor Surveillance System; CHEMS = community health emergency medical services; CHW = community health worker; EHR = electronic health record; ER = emergency room; health IT = health information technology; HIE = health information exchange; HN = Health Neighborhood; IDHW = Idaho Department of Health and Welfare; IHDE = Idaho Health Data Exchange; LTSS = long-term services and supports; NCQA = National Committee for Quality Assurance; PCMH = patient-centered medical home; PHD = Public Health District; PMPM = per member per month; QM = quality management; RC = Regional Health Collaborative (Idaho); SPA = state plan amendment.

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Appendix E: Iowa Site Visit Report

During the 2016 site visit, the RTI team conducted 15 key informant interviews, as well as two provider and two consumer focus groups in the greater Des Moines and Fort Dodge areas of Iowa from May 18 through May 20. The team also conducted two phone interviews for a total of 17 key informant interviews. The focus of the interviews was to learn about the context of Iowa’s health care system and early SIM implementation successes, challenges, and lessons learned. Interview participants included officials from state agencies or departments; and representatives from payers and purchasers, consumer advocate organizations, and provider organizations involved in the development and implementation of Iowa’s SIM Initiative. The RTI team spoke with the four focus groups—two with Medicaid-enrolled consumers and two with Medicaid-participating primary care providers (PCPs)—to learn about their experiences with the current health care system in the state, and their awareness, if any, of the Iowa SIM Initiative.

This appendix provides an overview of the Iowa SIM Initiative; describes the current health care context in which the SIM Initiative is being implemented; summarizes major early implementation successes, challenges, and lessons learned; and discusses key findings from the site visit interviews and focus groups organized by major topical area. This appendix includes findings based on qualitative data collected through June 30, 2016. Further details on the analytic approach are available in *Appendix L*. Information on the site visit interviewees for the state is in *Table L-1*, and information on the provider and consumer focus group participants for the state is in *Tables L-4* and *L-5*, respectively.

E.1 Overview of Iowa’s State Innovation Model

Iowa is undertaking a range of activities to facilitate community-based collaborations between payers, providers, and public health entities to address population health needs and create a more sustainable health care delivery and payment system in the state.⁴¹ The state’s SIM Initiative has three primary aims: (1) improve population health, with a focus on three areas—diabetes, obesity, and tobacco use—so as to reduce health care demand; (2) transform the health care system to provide higher quality care at lower cost and thereby reduce unnecessary care, including preventable hospital readmissions and preventable emergency room (ER) visits; and (3) promote the sustainability of system change by expanding the use of value-based purchasing.

In achieving those aims, Iowa has identified several specific goals for its SIM work. For instance, by 2018 the state is aiming to have 50 percent of Medicaid, Wellmark Blue Cross Blue Shield (Wellmark), and Medicare payments linked to value-based purchasing contracts and, at the same time, to reduce preventable ER visits and preventable hospital readmissions by 20 percent. Additionally, the state has set several population health goals, including a reduction in

⁴¹ Iowa Department of Human Services. (2016). *State Innovation Model (SIM)*. Retrieved September 7, 2016, from <https://dhs.iowa.gov/ime/about/initiatives/newSIMhome>.

obesity by 2.9 percent, an increase in the share of diabetes patients with two or more A1c tests in a year by 4.1 percent, and an increase in the attempted quit rate for tobacco use by 5.1 percent. However, the ultimate measure of SIM Initiative success from the state’s perspective will be continued growth of the value-based purchasing model across Iowa’s health care system after Award Year 4 has ended.

E.2 Logic Model

Figure E-1, located at the end of this appendix, is a logic model of Iowa’s SIM Initiative at the time of this writing, depicting the hypothesized relationship between specific elements of SIM and changes in outcomes. The first two columns describe the scope and context of Iowa’s SIM intervention. Column 1 defines each SIM element, including the population and providers that it targets. Column 2 shows the levers Iowa is using to implement each SIM element. For instance, Medicaid data-sharing arrangements are being leveraged to incentivize providers to engage in value-based purchasing, and learning collaboratives are an approach to facilitate Community Care Coalition (C3) development (see *Section E.3.7*).

The last three columns show the different ways that Iowa will measure outcomes of the SIM Initiative. These include (1) process measures, both Iowa-specific and measures for all SIM Round 2 Model Test states (Column 3); (2) model-specific impact measures that will compare outcomes across populations with different levels of exposure to Iowa’s SIM elements (Column 4); and (3) statewide impact measures that will assess whether Iowa has reached its SIM goals of improved quality of care and care coordination, lower health care costs, and improved population health (Column 5).

E.3 Implementation Activities

E.3.1 Context of health care system

Stakeholders noted three key elements of the Iowa health care system that provide the context for the state’s SIM Initiative. First, Iowa has a relatively small population, with an ongoing population shift from rural to urban areas. Second, Iowa’s health care market is highly concentrated, with only a few key health care system players across the state. Third, the state has a strong history of health care collaboration. A number of stakeholders noted that in a small state with concentrated plan and provider markets, the key players all know one another and, in Iowa, know how to work together. As one stakeholder put it, “Because we have very few entities that need to be brought to the table from a provider and payer perspective, [we can] get to the critical mass [needed] ... to actually be able to make change happen.” Prior to the SIM Initiative, Iowa’s health care system had already come together to support a number of other system transformation activities. Examples include activities of the Iowa Healthcare Collaborative, an organization formed by the Iowa Provider Association and the Iowa Hospital Association in 2004 to “promote a culture of continuous improvement in health care” in the state; the Healthiest State Initiative, which was started in 2011 to support a community-focused effort to make Iowa

the healthiest state in the nation; and a 20-year history of coming together to address population health issues through the well-established Community Health Needs Assessment and Health Improvement Plan (CHNA&HIP) development process, which takes place at the county level. As discussed further below, the Iowa SIM Initiative takes advantage of this robust history of collaboration, building on initiatives and relationships in place in both public and private sectors prior to the SIM Initiative.

Several challenges complicated Iowa's initial SIM implementation. First, the original plan was to learn from and build on the accountable care organizations (ACO)-related activities of Wellmark, the largest commercial plan in the state, and Medicare. Both Wellmark and Medicare have been supporting development of ACOs in Iowa since 2012, including the Shared Savings Program, Pioneer, and Next Generation ACOs under Medicare. Expanding on these existing ACOs to serve the Medicaid population was a key component of Iowa's initial SIM design. Further, Wellmark has a long history of relying on value-based purchasing in its relationship with providers across the state, which provided the template for Iowa's move toward statewide value-based purchasing in Medicaid. By building on Wellmark's model, which uses quality reporting (based on a Value Index Score [VIS] developed by 3M) and some level of value-based purchasing with every PCP with whom it contracts, the SIM Initiative is intended to create an alignment in incentives for providers across Medicaid and most of the commercial market in the state. However, the move to value-based purchasing and the expanded role of ACOs in Medicaid were disrupted by the state's decision to shift from a Medicaid fee-for-service (FFS) program to fully capitated managed care between 2015 and 2016. Announced by the Governor in January of 2015, planning for and implementing Medicaid managed care by 2016 required significant staff time in the state, as did reframing the SIM Initiative to incorporate the role of managed care organizations (MCOs). As discussed in more detail below, the shift to Medicaid managed care delayed implementation of key elements of Iowa's SIM Initiative by more than a year.

Second, the state lacks a fully developed health information technology (health IT) system. Not all providers have health IT systems and those that do often use different systems, even within existing ACOs. Stakeholders noted that hospitals and clinics in the same community often use different systems, which makes both the sharing of data to support care coordination and the compilation of the data to support value-based purchasing efforts difficult. Some stakeholders quoted the latter as a particular concern, as the state's value-based purchasing model is to be based on a detailed compilation of data on the commercial and Medicaid populations.

Third, the care delivery systems for public health, medical care, behavioral health care, and long-term services and supports (LTSS) have been siloed in Iowa. In particular, mental health services are provided by one agency (Iowa Department of Human Services [IDHS]) and substance abuse services by another (Iowa Department of Public Health [IDPH]). Although the

state had started efforts to build a more integrated system of care prior to the SIM Initiative by the time of the 2016 site visit, including a redesign of the mental health system, the SIM Initiative will require building new relationships across the different care systems in the state, particularly at the community level. Stakeholders viewed the latter as especially challenging in small rural communities, where available resources are already stretched thin.

Finally, stakeholders viewed the existing cost-effectiveness of the health care system in Iowa as leaving little fat in the system to cushion against: (1) ongoing uncertainties in the health care market related to the Great Recession, (2) the system-wide changes introduced under the Affordable Care Act (ACA), and (3) the unexpected shift of Medicaid to managed care in the state already noted, as well as concerns about the implications of the results of the 2016 national election for the health care system. Some stakeholders said these uncertainties make them hesitant about investing fully in the changes envisioned under the SIM Initiative.

E.3.2 Governance and program administration

The Iowa SIM Initiative, which is housed within Iowa Medicaid Enterprise (IME) in IDHS, is a collaboration between IDHS, IDPH, and the Iowa Healthcare Collaborative.⁴² As noted above, the Iowa Healthcare Collaborative is a private initiative focused on improving health care in the state. Less formally, the SIM Initiative is planned as a collaboration with payers, providers, public health, and community leaders across the state to develop partnerships across all sectors and communities in Iowa to support system change—as one interviewee described it, to “change the culture of health” across the state. Because the goal is systematic and sustainable change within the state, significant resources have been devoted to build a broad constituency to support system change at the state and community levels.

E.3.3 Stakeholder participation

Described by one stakeholder as a “master’s class in collaboration,” Iowa has invested in a strong stakeholder engagement process, which includes both community-level and statewide outreach to payers, providers, public health, and other stakeholders. The state’s current engagement efforts are organized around four teams: a Core Planning team, a Leadership Team, an Implementation Team, and an Alignment and Action Team. The Core Planning team focuses on bringing together payers, providers, and public health to focus on aligning goals and objectives under Iowa’s SIM Initiative. The Leadership Team of key stakeholders within the payer, provider, and public health communities provides the leadership needed to ensure the SIM Initiative stays on track within their different constituencies. The Implementation Team addresses implementation of SIM components and day-to-day operations under the SIM award. Finally, the Alignment and Action Team brings the voices of those affected by SIM activities (payers, providers, public health, and consumers) to the table, including members of the Medical

⁴² Iowa Department of Human Services. (2016, January). *State Innovation Model grant operational plan—2016*. Retrieved September 7, 2016, from https://dhs.iowa.gov/sites/default/files/SIM_Operational_Plan_20160122_AmendedforOAGM.pdf.

Assistance Advisory Council. Most, if not all, stakeholders interviewed reported participating in some part of the SIM stakeholder engagement effort themselves or via a representative from their organization. Nursing homes and assisted living providers were reportedly not initially engaged with the SIM Initiative; however, stakeholders said that may change with managed care implementation for the full Medicaid population.

Stakeholder engagement activities have involved statewide and local public forums, work groups to address specific issues, committee meetings and forums to target specific populations and issues, newsletters and dedicated websites, and learning collaboratives (called Learning Communities in Iowa), among other things. Stakeholders reported active engagement in the SIM Initiative, with an open and collaborative relationship between the public and private sectors and among payers, providers, and public health. Stakeholders expressed some concerns, however, that the information from the IDHS “stopped” during the transition period to Medicaid managed care, particularly around issues relating to reimbursement, value-based purchasing, and how the MCO roll out would affect the goals of SIM. This created some uncertainty as to the future direction of the SIM Initiative. The same stakeholders felt that communication from IDPH around the C3s and other public health issues had been excellent.

Overall, stakeholders praised the state’s efforts to implement the SIM Initiative, especially given the unexpected shift to Medicaid managed care and what was described as lean funding to support implementation. However, some stakeholders expressed concern about the end of the SIM award—specifically, the need for sustainability strategies for the state’s system transformation efforts, given the delay in implementation with the roll-out of Medicaid managed care and the relatively brief SIM funding period. Some were apprehensive about investing in change, particularly at the local level, without more evidence that the changes would be supported beyond Award Year 4. On this note, some stakeholders felt that sustainability should be a stronger focus for Iowa’s SIM Initiative before the end of the funding period—with an emphasis on local budgeting, potential philanthropic partners, or other funding models that would allow the C3s to continue their activities once federal grant money was no longer available.

An additional concern expressed by some stakeholders was that introduction of managed care into Iowa Medicaid has changed the structure of the collaboration around SIM implementation in Iowa, placing an additional entity—the MCOs—between providers and the state agencies (as described further below).

E.3.4 Delivery systems and payment reforms

Iowa’s initial plan for its SIM Initiative was to introduce ACOs into the Medicaid program, creating an alignment in care delivery with the existing Medicare ACOs and the ACOs serving the privately insured under Wellmark. Further, the ACOs were to be paid based on a new

Medicaid value-based purchasing model that leverages the model long used by Wellmark, creating an alignment in payment systems across payers for most PCPs in the state.

Although the efforts to implement an ACO model in Medicaid began in 2014 with the expansion of Medicaid under the ACA, the Governor's January 2015 announcement of plans to shift to fully capitated managed care for the entire Medicaid population in 2016—which represented a substantial shift in care delivery for the Medicaid program—led to a forced restructuring of Iowa's SIM Initiative to step back from direct engagement with ACOs. Under the new plan, Medicaid MCOs are to take the lead in contracting with ACOs and other providers to care for the Medicaid population, implementing value-based purchasing within these contracts. The IDHS's expectation is that the MCOs will also interact with other components of the SIM Initiative to support community-based care coordination and public health initiatives across providers and within communities. Thus, the introduction of managed care adds another layer to the health care system, which several respondents said increases the complexity of implementing changes under the SIM Initiative.

The shift to Medicaid managed care began in April 2016 with contracts with three MCOs, all new to the state. Many stakeholders, including stakeholders representing the MCOs, expect the first year of Medicaid managed care to focus on establishing program operations and learning about the needs of Medicaid enrollees in Iowa. Thus, development of value-based purchasing strategies and community-based care coordination and public health initiatives will be a lower priority for MCOs in the short run—even though, as noted, the MCOs are required to have an aligned form of value-based purchasing in place in provider contracts for at least 40 percent of the Medicaid population by 2018. Payments under those value-based purchasing strategies are to reflect both the care provided directly to those Medicaid patients and health care outcomes within the broader community, although the metrics for developing those payments were not yet in place at the time of the 2016 site visit.

The slowed implementation of the core components of the SIM Initiative in 2015 and 2016, along with some uncertainty about the interactions between the SIM components as they are operationalized by the MCOs, has raised concerns among some stakeholders. They expressed fear that it will be difficult to establish the momentum with value-based purchasing needed to create the changes envisioned under the state's SIM Initiative to sustain health system transformation beyond 2018. Many stakeholders perceive the shift to value-based purchasing to be the key driver for long-term system change—the third aim of the Iowa SIM Initiative.

At the time of the 2016 site visit, Medicaid managed care had only been in place a few months, so the health care system was still very much in flux. During the focus groups, Medicaid-participating providers expressed concern about the complexity of dealing with three unique systems across the MCOs—separate transportation vendors, different benefit packages and drug formularies, and different rules on prior authorization, all with different paperwork requirements. This new arrangement was seen as substantially increasing the administrative

burden of Medicaid for the same reimbursement rates, and creating barriers in the way of a consistent level of care for Medicaid patients across health plans. Medicaid-participating providers in the focus groups, for instance, expressed frustration with what they viewed as unreasonable requirements for contracting with the MCOs, and also with MCO processes for prior authorization and step therapy (the common name for a process that begins treatment for a medical condition with the most cost-effective drug therapy and progresses to other more costly or risky therapies only if necessary). As one provider in the Des Moines area explained, “I find myself apologizing for the insurance companies [to my patients] because I can’t get the pumps or insulin they need. . . . I feel bad for the patient because as a provider I should be able to make the decisions; they shouldn’t be made in an ivory tower.”

These concerns were echoed during focus groups with Medicaid beneficiaries themselves, particularly among those in the greater Des Moines (Dallas County) area. Beneficiaries described confusion and frustration about the changes. Specifically, they said they found it difficult to figure out which MCO they are enrolled in, their assigned PCP, and whether their existing providers are in the network of their new plan. Referrals have become more complicated, and many beneficiaries spoke of struggles with preauthorization for prescription drugs and services. One spoke of visiting the ER to obtain medication rather than waiting through a lengthy preauthorization process.

Stakeholders also noted disruptions in relationships in the community, as community-based initiatives under the SIM Initiative (described below) must now work through MCOs rather than ACOs to develop a community-based care coordination model that will be sustainable, and public health is “not quite at the table” to give input into MCO decisions. Stakeholders also said it appears that behavioral health and substance abuse providers and long-term care providers are not at the table either, as MCOs are just beginning to develop those networks. Stakeholders reported a bit of a scramble: (1) by providers to retrofit the delivery system change envisioned under the SIM Initiative to accommodate MCOs, and (2) by MCOs to begin caring for the full Medicaid population, including older, blind, and disabled persons.

The core driver of system change under the Iowa SIM Initiative, as noted, is to be the alignment of payment reform across payers using value-based purchasing. By introducing a variation of the value-based purchasing model used by Wellmark to the Medicaid program, the state intends to align the incentives across providers for the majority of their patients. With the shift to Medicaid managed care, value-based purchasing is to be introduced over time through MCO contracting, which is expected to result in somewhat different models under each MCO.

A core component of the value-based purchasing model is use of a VIS, a composite measure of PCP performance based on claims and encounter data. The VIS, which is to be reported monthly to providers, will provide information on provider and system performance to be used for: (1) performance improvement, and eventually (2) financial incentives to support a value-based delivery system. The Medicaid VIS model, like the Medicaid value-based

purchasing system overall, is to build on the VIS model Wellmark uses for the commercial market.

Developing a VIS system for the Medicaid program raises a number of challenges, however. First, the VIS model already implemented by Wellmark will need to be augmented for Medicaid to reflect the needs of the entire Medicaid population—which includes incorporating measures related to behavioral health, long-term care, and social determinants of health. Second, the state will need to collect claims and encounter data that is complete and reliable—something that is not yet in place and, from some stakeholder perspectives, is unlikely to be in place any time soon. Third, measures and reporting structures will need to be developed to provide feedback based on the VIS that is useful for different constituencies (such as providers, MCOs, and communities).

Provider stakeholders, in particular, expressed concerns about the “black box” of VIS measures, and the expectation that providers would be responsible for health outcomes for patients who were not part of their caseload or were only enrolled for a short time. One stakeholder explained, “You have to have someone assigned and enrolled and engaged with a PCP for a certain period of time [to improve outcomes]. That doesn’t happen all of the time in Medicaid. Most of our members are kids and moms. The moms come on for pregnancies and the kids come on and off too.” Another noted that, with Medicaid managed care and value-based purchasing, providers were aware that there will be less money in the system at the same time that they will have greater administrative burden, be expected to play a more active care coordination role, and be expected also to invest more in community initiatives. Similarly, MCO stakeholders expressed concern that providers could be attributed to their plans to calculate VIS measures, but that the current system could not identify the MCO members who were being seen by those providers—making it difficult to assess MCO performance. Both provider and MCO stakeholders expressed concern about how VIS measures would be constructed and used under the value-based purchasing model, with MCOs working to incorporate the VIS measures into their existing proprietary performance measurement systems. Some also raised the possibility that the introduction of new scorecards and dashboards related to VIS and each of the MCOs may result in “information overload” for providers, or a large volume of information that providers are unable to interpret or use in a straightforward and efficient way.

Medicaid providers who participated in the focus groups were generally familiar with the value-based purchasing concept. Many had experienced it in the form of bonus payments or withholding for meeting certain quality measures, but only one had experienced a shared-savings arrangement. Although her practice had benefited from the arrangement, she noted that the per provider incentive payment was relatively small (a few thousand dollars to be split among several physicians). Though focus group providers agreed that value-based purchasing had a good purpose, some also noted that it may penalize them for actions (or inactions) over

which they have little or no control, like whether patients fill prescriptions and comply with medication schedules.

E.3.5 Health information technology and data infrastructure

Efforts to improve care coordination and information sharing through the SIM Initiative depend on a strong health IT infrastructure, but Iowa continues to struggle with electronic communication among stakeholders and systems. Many large provider groups in Iowa use the Epic system as their electronic health records (EHRs), but independent providers, particularly specialists, have poor EHR adoption, mostly because of the high cost of establishing health IT. Lack of interoperability is also an obstacle. One stakeholder observed, for instance, that Iowa has a very strong critical access hospital system, but that these hospitals are not engaged in shared health IT and “don’t talk to one another.” Medicaid-participating providers in the focus groups expressed frustration about fragmented EHR systems, which they said hindered care coordination and quality and often led to redundant tests or wasted office visits. At the same time, some providers associated with large systems using Epic praised the information sharing this electronic system enabled, noting that it improves quality in multiple ways (including by preventing waste and helping providers ensure nothing is missed).

To address barriers to electronic information sharing across providers and regions, Iowa created the Iowa Health Information Network (IHIN), a voluntary system that shares electronic patient health information among authorized users. The IHIN is designed to encourage secure direct messaging among a variety of users (including hospitals, large health systems, independent providers, and public health departments). Since large systems already have expensive EHR solutions, stakeholders felt that the IHIN could be most useful as a platform to connect smaller unaffiliated providers with major hospitals. However, most respondents felt that the IHIN had not lived up to its potential and had failed to attract enough provider interest to become self-sustaining. Some pointed specifically to the fact that providers must pay a fee to join the IHIN, and felt that this feature in particular had hindered participation.

In an effort to expand the IHIN infrastructure and increase provider interest in participating in information-sharing, Iowa’s SIM Initiative includes a Statewide Alert Notification (SWAN) system. The SWAN system was designed to allow providers to obtain timely information when their patients are in the hospital, allowing them to follow-up and work with others to coordinate care for the patient. IME worked with a contractor to build the SWAN technology, and has begun to roll out the SWAN with an early focus on ACO-led provider systems in 2016. Ease of implementation has varied depending on the technical capacity and commitment of the given health system, but state officials expressed confidence that progress is being made. During April 2016, 21 hospitals were connected and the system generated 2,474 alerts. The state’s next goal is to connect smaller hospital systems and MCOs to the SWAN system.

IME has been working to slowly introduce SWAN to providers. For example, although the technology is intended to provide real-time alerts, IME staff have been sharing alerts with providers periodically in batches—so these providers can develop the processes needed to use this information, rather than suddenly receiving a constant stream of information they are not prepared to use.

Many stakeholders agreed there is great value in the type of information SWAN provides, but felt more work has to be done for the data to be useful and, in some cases, described SWAN as duplicating other internal efforts. For example, one health care organization that received SWAN alerts at the time of the 2016 site visit reported not yet using the information because their organization cannot determine which of its multiple service sites is the health care provider for which patients on the list. Some stakeholders, including providers and C3s, were not yet aware of SWAN or the type of information it makes available. Others said they can already get some admission, discharge, and transfer (ADT) information through their relationship with a hospital, particularly hospitals using the Epic system, which allows outside entities to be given access to log in and see the records for particular patients. Finally, the MCOs viewed SWAN as potentially duplicating their own internal systems and so, while they will accept the data, stakeholders were not sure what they accept will add value to the organizations. Although the state’s goal is for SWAN to be supported by provider and MCO investments, some stakeholders expect to be a “hard sell,” given the duplication with other systems.

Also relevant to the health IT systems in the state, VIS success depends on the ability of the MCOs to collect claims and encounter data quickly and seamlessly. Some stakeholders were concerned the MCOs will not embrace the VIS, or will complicate data collection efforts as they integrate their existing performance management systems with the new VIS structure. One stakeholder suggested it will be a major challenge to get VIS information out in a way that retains data integrity, given the presence of three different MCO data systems. Other stakeholders were more confident that these technical challenges can be overcome, despite broader concerns about VIS. One explained, “The MCOs did push the issue and made sure [alignment between VIS and internal processes] happened right after they got the contract. I think the news from the MCOs and the state has been positive as far as how that handshake will go.” State officials echoed this point, indicating confidence that they will obtain usable encounter data for the VIS.

E.3.6 Workforce development

Workforce development represents a significant challenge for the Iowa health care system, but efforts to deal with workforce issues are occurring outside the SIM Initiative and not a key component of the state’s SIM strategy. Respondents agreed that Iowa suffers from shortages of health care providers and administrative staff, particularly in rural communities that struggle to provide competitive salaries and benefits. This affects all medical staff, including the non-physician providers responsible for a good deal of care in rural communities. Although

many specialists (such as endocrinologists, ophthalmologists, and dermatologists) were difficult to access for low-income patients in rural areas, according to stakeholders, workforce gaps were especially severe for mental and behavioral health.

In the focus groups, both Medicaid-participating providers and Medicaid beneficiaries explained that behavioral health providers are in short supply, and the few that do practice in rural areas often have long waiting lists. For lack of alternative options, PCPs said they find themselves providing basic behavioral health care, though several emphasized the limits to this approach. As one provider explained, “In the rural setting, if a patient is threatening to kill themselves there is nobody you can send them to—they are closing inpatient psychiatric facilities in Iowa. Getting ahold of psychiatrists is very hard to do.” Though there are more providers in the state’s metropolitan areas (including Des Moines), rural-residing beneficiaries often do not have the resources to travel for behavioral health services. Telehealth appears to be an option in some cases, though one Medicaid beneficiary described a negative experience with this model of care: “I had to talk to a doctor through a video which I thought was very discriminating and downgrading. She couldn’t even be in the office with me and I don’t think she truly understood what I was there for and I never went back.”

Most interviewees said they feel there are enough care coordinators in the state to do the health coaching work being supported by large provider systems. However, the switch to Medicaid managed care has led to disruptions in this segment of the workforce, as the MCOs have sought to hire large numbers of nurses and case managers from existing health systems to perform care coordination and related activities.

To address these longstanding issues, Iowa has implemented several initiatives over the last decade—including a Direct Care Worker Task Force, which led to creation of the *Prepare to Care* training curriculum for health care workers; a Medical Residency Training State Matching Grant Program; and a Health Workforce Program Analysis conducted by the Rural Policy Research Institute in 2015. One state official described the Institute’s work as a comprehensive analysis of workforce programs within IDPH, but also noted that the legislature has requested a study of workforce more broadly (outside IDPH), which was planned to occur over the 6 months after the 2016 site visit.

All stakeholders and state officials agreed that workforce development was not a significant component of the SIM Initiative. They recognize the efforts described above as having an impact on SIM-related activities—but as a direct result of, funded by, or integrated with the SIM Initiative. Some stakeholders did note that the SIM-funded statewide Learning Communities involve skill-building that relates to developing a competent workforce, including sessions around topics like social determinants of health, medical neighborhoods, and chronic care.

Workforce-related innovations are expected to continue as part of the state's broader transformation efforts outside the SIM Initiative. Potential reforms could include expanding the type or number of providers who can perform certain services, changing licensure requirements for particular workforce segments, or making further investments in residency programs and efforts to keep doctors in the state. At the same time, several stakeholders felt the SIM Initiative should have included additional workforce-related initiatives.

E.3.7 Population health

The SIM Initiative is expected to build the infrastructure for continual population health improvement, which is to include three major strategies:

- ***Development of statewide plans recommending evidenced-based approaches and clinical indicators that can be used to improve quality, related to various health conditions and areas of care.*** So far, Iowa has developed plans for tobacco use prevention, diabetes, health care–associated infections, medication safety, nutrition and physical activity, and obstetrics. A statewide plan is currently in progress around care coordination. Communities are encouraged to align with these plans as they identify needs and plan to address them through their CHNA&HIPs—an assessment and plan for improving county health measures that local health departments must update every 5 years.
- ***Development of a database to assess and track clinical indicators that communities target through their Community Health Needs Assessment and Health Improvement Plans.***
- ***Rapid-cycle improvement around population health measures driven by Community Care Coalitions.*** C3s are locally based coalitions of health and social service stakeholders that coordinate services across systems of care and care settings. C3s also align priorities with their community's CHNA&HIPs. The C3s are the primary mechanism for community-based change under Iowa's SIM Initiative.

The C3s are being implemented by the IDPH, with technical assistance (TA) available through a subcontract between IDPH and the Iowa Healthcare Collaborative. This TA involves coalition building and rapid-cycle improvement through learning communities, site visits, and one-on-one coaching. Community-based coalitions were invited to apply for either a developmental grant to focus on coalition building or, if a coalition is already in place, an implementation grant to begin implementing strategies in their communities. The SIM team received 21 applications, and ultimately selected six collaborations for the first C3 awards in March 2016. The current C3 awards represent 20 of Iowa's 99 counties (10 counties in developmental C3s and 10 counties in implementation C3s). The state said it expects to fund more C3s in the future.

The initial group of C3s represent a broad range of communities, models, and readiness to implement their strategies. Some interviewees observed that the C3s need much more help around coalition building and understanding the community-based model than anticipated.

Multiple stakeholders mentioned the C3 strategy as being “population-based, community-applied,” which represents a shift in thinking from the traditional delivery system–based model. Consequently, these stakeholders anticipate the model will take some time to build. Apprehension about how the new community-based approach may ultimately influence reimbursement models or require health care providers to “give up territory” has prevented some stakeholders from participating in the C3 effort. By starting with a small number of C3s, the SIM Initiative aims to apply population-based health care in a few communities at a time. IME is also planning to pilot the sharing of SWAN information with one C3 to figure out how C3s can best use the information.

C3s are a continuation of the Community Care Team Pilot, which had been based on North Carolina’s Community Care Networks.⁴³ The pilot, which funded six community care teams, was implemented by the Iowa Primary Care Association (IPCA) with funding from the Iowa state legislature. Two of the new C3s were part of the original pilot; others from the pilot had applied but were not selected, because—according to one stakeholder—their focus did not align with the SIM Initiative’s focus on diabetes, obesity, or tobacco use. However, two of the funded C3s suggested these foci were broad enough that it was relatively easy to frame their applications to match what they were already doing. While interviewees reported that the C3s were built on the lessons from the pilot, the IPCA was not included in the design or implementation of C3s under the SIM Initiative.

Most C3s are led by local health departments, with a minority led by a health and hospital system. Some are aimed at serving a single county; others are a partnership among multiple counties. Given the rural nature of much of the state, partnerships among counties are common, because they provide the population base and staffing needed to be sustainable. For example, one multi-county C3 is led by a local public health department that also provides administrative services (through a contract) for the public health departments in the other counties they are partnered with for the C3 (an arrangement that pre-dated their partnership as a SIM C3). The declining rural population in Iowa poses a number of challenges for C3s, in terms of both having a sustainable population base and the clinical and administrative workforce available to run the C3s. The steering committee of this multi-county C3 joked they spend a fair amount of time trying to recruit one another to fill vacancies in their respective organizations, because there is such a limited workforce with the skillset they need. They cited workforce shortages of physicians, as well as registered nurses, licensed practical nurses, nurse practitioners, and social workers.

Another challenge for C3s is the need to prove their value before the SIM funding period ends. To be sustainable, C3s must demonstrate their value in supporting the goals of value-based purchasing, so a health care entity (such as the MCOs) will have an incentive to pay them for

⁴³ More information about North Carolina’s initiative can be found on the Community Care of North Carolina Web site, at <https://www.communitycarenc.org/>

their work. Stakeholders associated with a C3 that was part of the pilot effort said C3s had demonstrated their value to the local health system, by achieving reduced costs via care coordination and connecting high-risk, high-cost health system users with needed social services. This C3, which multiple stakeholders described as the most advanced of the C3s funded at the time of the 2016 site visit, was able to document cost savings in case studies of individual patients they had served. Notably, that coalition was first established in response to a local health system becoming a Medicare ACO, which incentivized the health system to work with public health entities in a way they had not done previously. The local health system indicated it was willing to fund this stakeholder's Community Care Team (the precursor to its C3) after the pilot ended if it was unable to secure funding through the SIM Initiative. However, as Iowa has shifted to Medicaid MCOs, the MCOs are developing their own internal care coordination infrastructures, which C3s must now compete with to demonstrate value.

While the CHNA&HIP process long pre-dates the SIM Initiative, development of statewide goals and approaches is aimed at increasing their impact. The public health infrastructure—which includes the CHNA&HIPs, C3s, and the statewide plans—is intended to build the statewide capacity to address a broad array of population health topics in the future. As one stakeholder described, “the core C3 strategy kind of bridges from population health improvement to the care coordination ... and then the rapid cycle improvement piece generates the repetitive work that's got to happen in the C3s in order to improve the work that they're doing at the community level Those three drivers are linked at the hip.” Development of statewide plans under the SIM Initiative has included various stakeholders, which was described by multiple interviewees as a very positive step toward developing a common vision.

One challenge in focusing on population health that multiple stakeholders mentioned was getting everyone to agree on what is meant by population health. As one stakeholder noted, each partner defines population health differently—with Wellmark naturally focusing on their covered lives in the commercial market; IME on Medicaid beneficiaries; IDPH on the state population more generally (although broken up by counties); and the Iowa Healthcare Collaborative on population health, in part as a way to help providers prepare to survive in a value-based purchasing environment.

An additional challenge is implementation of a rapid-cycle improvement approach in the public health community, where such structured activities are rare. While some public health departments have used this type of structured quality improvement process before, it is new to others; and few data are available to track and inform their work at implementation. The Iowa Healthcare Collaborative, which is providing C3s with TA around rapid-cycle improvement under the SIM Initiative and has experience leading quality improvement efforts among providers, is also new to implementing such activities within community-based organizations.

E.3.8 Technical assistance and other support resources

The Iowa SIM team has been generally satisfied with their interactions with CMMI. Several state officials noted there had been several changes to Iowa’s assigned project officer that may have led to confusion around administrative issues. The state’s award carryover request was also challenging to complete, since CMMI’s guidance on this was delayed. Officials were appreciative of the TA they had received, but some expressed the wish that CMMI would be more proactive in providing information about strategies and lessons learned in other SIM states. Stakeholders also suggested that CMMI organize a second nationwide in-person SIM meeting, to facilitate information sharing and relationship building among SIM states.

E.3.9 Progress, challenges, and lessons

Based on the SIM Initiative implementation experience as of the 2016 site visit, stakeholders offered a number of lessons and remaining challenges. Major themes include the importance of collaboration among payers, health care providers, and public health entities, as well as the challenge of introducing the different SIM components in the midst of other changes in the health care environment—most notably implementation of Medicaid managed care. Stakeholders also mentioned lessons and challenges related to the resources available to implement the SIM Initiative.

Collaboration and alignment

Although the major players in Iowa’s health care system already had a history of collaboration, the goals of its SIM Initiative have incentivized these players to align even more, and many stakeholders mentioned widespread and sincere willingness to work together on the SIM Initiative. One stakeholder summarized by saying, “For the first time we have payer, purchaser and provider community actually pulling the same wagon versus competing against each other.” However, while there have been extensive efforts related to collaboration between Medicaid and public health, conversations with provider associations and individual physicians indicated that the provider community itself has been less engaged in the SIM Initiative.

Consistent with this, interviewees from the provider community were less likely than other stakeholders to expect the SIM Initiative to be a major driver of change. Some voiced skepticism (particularly among hospitals) that there will truly be payment reform, and some said they have received very little information about what the value-based purchasing arrangements will look like—although one stakeholder organization mentioned it has already changed the way it provides care and is hurting financially from reduced ER visits and inpatient admissions. Another stakeholder highlighted what he viewed as a disconnect between performance and payment, and wondered whether performance improvements could be sustained if reimbursement methodologies were not aligned with changes in quality metrics and benchmarks. Alignment between Medicaid and Wellmark using VIS has also proven more challenging than expected, as noted, given that it was not designed for a Medicaid population. In addition,

considerable confusion was apparent among providers as to what the VIS is measuring and how they can use it to drive improvement.

One area where there has not been a strong history of collaboration in Iowa is among medical providers, behavioral health, and LTSS. This was in part driven by Medicaid having previously carved out these services to another entity, and within behavioral and disability services there have been siloes as well. Behavioral health services administration, as noted, is separated for mental health and addiction services—with two separate state agencies and two separate accreditation processes—at the system level and the individual provider level. In addition, workforce shortages (including shortages among behavioral health providers) further complicate the future of collaboration. Even so, multiple stakeholders expressed optimism that the SIM Initiative will help break down divisions and will particularly encourage PCPs and behavioral health providers to work together.

Finally, stakeholders voiced concern that behavioral health and LTSS have not been sufficiently engaged in the C3 efforts. In addition to the need for diverse provider types to collaborate, interviewees mentioned the challenge of pointing different C3 communities in the same direction (i.e., towards the statewide goals of the Iowa SIM Initiative). One stakeholder explained, “The multi-county areas are very different than the single county areas because they have to figure out how they’re going to implement in a bigger region and across those boundaries that are self-defined as a county...we always say if you’ve seen one public health department then you’ve seen one out of the 99 communities we have.”

Introducing change in a dynamic environment

The Iowa SIM Initiative is being implemented in the midst of many other changes in the state’s health care system. On the one hand, stakeholders perceived this as positive, given that everyone is already in the mindset of change. But on the other hand, in the words of one stakeholder, “people are tired physically and mentally. They’re still trying to figure [out] ACOs, the [ACA] Health Insurance marketplace, and the Medicaid managed care roll-out, and now the SIM thing is coming in. It’s a lot going on.” The MCO launch may be the biggest single barrier to the success of the Iowa SIM Initiative—even though, in principle, the goals of managed care appear to align with the SIM Initiative’s focus on value-based purchasing and population health.

Those involved with SIM leadership and implementation did not describe it as a major change from the original focus on ACOs, or in conflict with the goals of the SIM Initiative, although they did acknowledge that the ongoing changes outside the SIM Initiative make SIM implementation more complex. However, the view from the ground was quite different. Some stakeholders felt that the shift to Medicaid managed care had transformed SIM from being focused on the needs of the state to being more focused on reducing costs in Medicaid.

Several aspects of the MCO model emerged throughout conversations with stakeholders as being potentially in conflict with the intent of the SIM Initiative. For example, while the SIM

Initiative was aimed at developing a statewide approach to improve population health, the fact that there are now three different MCOs makes it challenging for providers to view their patients as a single overall population, when each MCO is different in terms of whether and how services will be reimbursed. In addition, stakeholders noted that the transition period occurring at the time of the 2016 site visit—in which patients may have had to switch PCPs based on their new MCO and its network—has made the patient attribution needed to manage a patient population’s health in an integrated way much more difficult.

Finally, while a major intent of the SIM Initiative was to empower partnerships at the local level that address social determinants of health, the widespread perception is that the shift towards MCOs has taken control out of the local level and put it into the hands of national health plans. Stakeholders at the local level said they often felt the national health plans do not understand the “Iowa way”—which was often described as involving face-to-face relationship building and a boots-on-the-ground approach, all with a strong sense of collaboration. For example, MCOs are implementing care coordination by phone, which contrasts with both the in-person care coordination many stakeholders are familiar with and the Wellmark approach, which is to delegate care coordination to individual practices. MCO representatives reported that their health plans did in fact hire many local employees who have lived and worked in Iowa all their lives. However, multiple stakeholders shared the perception that anyone affiliated with the MCOs was from “New York” or somewhere out of state. The MCOs recognized that this misperception made it challenging to build relationships with health care providers.

Resources

Respondents agreed that SIM resources were sufficient overall, and that the state had done a good job of operating within a lean structure. However, multiple stakeholders felt that the individual C3 grants might not be enough money to sustain innovation in the designated communities. The bigger concern for state officials and other stakeholders alike was whether the SIM Initiative’s 3-year timeframe was long enough for change to truly take hold, given the ambitious nature of the project and the complications brought on by the switch to Medicaid managed care. In the words of one state official, “It’s a short time to make a lot of hay.” Other respondents were confident that change would continue after the end of SIM funding, given the state’s strong historical commitment to health care reform and the national movement toward value-based purchasing under the ACA and Medicare Access and CHIP Reauthorization Act (MACRA) legislation.

E.4 Statewide Changes

Since the SIM Initiative was still in the early stages of implementation and adjusting to the unexpected shift to Medicaid managed care at the time of the 2016 site visit, the RTI team is unable to report on any changes in outcomes or baseline measures. However, stakeholders shared perspectives about the aspects of Iowa’s health care delivery system the SIM Initiative is most likely to influence, as well as the likelihood that it will succeed in meeting its goals, both within

the 3-year award period and in the longer term. Overall, stakeholders expressed concerns that the shift to Medicaid managed care, which stalled much of SIM's implementation progress for 1 year or more, meant that significant changes for many outcomes within the 3-year period of the demonstration are unlikely, although they were more optimistic about longer term impacts. Within the SIM test period, stakeholders were most optimistic about seeing changes in population health measures, particularly in the C3 communities, as the SIM Initiative builds off on-going community-based population health efforts.

E.4.1 Health care expenditures and utilization

Though many stakeholders touted Iowa's "low-cost, high-quality" health care delivery system, they also recognized the need to tackle growth in health care expenditures, particularly given the state's aging population. (One interviewee reported that in the next 15 years the proportion of Iowans ages 65 and older is projected to nearly double.) Similarly, though stakeholders and focus group participants shared examples of how the Iowa delivery system is evolving incrementally to address inefficient use of the health care system (e.g., reduced duplication via shared EHRs under Epic's "Care Everywhere" feature and PCPs that establish urgent care programs for ER diversion), they agreed there is room for improvement, especially related to preventable health care events. One official shared that 70 percent of ER visits among Medicaid beneficiaries are potentially preventable.

The SIM Initiative aims to address growing health care expenditures and inefficient use of the health care system, by accelerating the transformation of health care delivery in Iowa from a volume- to a value-based system. Each of the major SIM components is expected to play a role in this transformation—value-based purchasing as an approach that will link provider payments to improved health care performance (rather than payments based on volume of services); SWAN as a tool that increases the flow of timely health event data to payers and providers, so they can target care coordination resources; the C3s as a structure for coordinating health and social services across care settings in a streamlined, efficient way; population health improvement strategies that strengthen communities' ability to address prevalent health care problems via collaborative and evidence-based approaches; and community-based performance improvement and TA, to assist providers and community partners with health system transformation activities.

As the SIM Initiative's primary lever in the transition from a volume- to a value-based system, value-based purchasing has widespread support in Iowa. Stakeholders viewed the SIM Initiative as propelling the spread of value-based purchasing across multiple payers, but emphasized that Iowa had already been heading in that direction. As one explained, "I don't think SIM will be the driver of the change [from a volume- to a value-based system]. We're already on that track. But SIM can make sense out of some of the capacity that we'll need to do value-based purchasing successfully." At the same time, as a state with a significant rural population and many low-volume providers (including the state's 82 critical access hospitals),

Iowa faces unique challenges in moving from a volume- to a value-based system. Some stakeholders questioned whether critical access hospitals, caught up in what they described as a “low-volume treadmill” that relied heavily on hospital admissions for revenue, are prepared to partner with other organizations on activities that aim to reduce inpatient and ER volume.

The Iowa SIM Initiative has not developed any specific goals related to health care costs. As noted, stakeholders had difficulty imagining that in a 3-year period there will be cost savings in the delivery system that can be directly linked to the SIM Initiative. They were also concerned about using cost trends as a metric of success, feeling that it will set the project up for failure. They noted that some population health improvement activities may actually increase certain costs in the short run (e.g., doing more health screenings or providing more tobacco cessation treatments) though eventually saving the health care system dollars by reducing chronic or acute disease. Moreover, although addressing social determinants of health—a specific goal of C3 communities—is typically not part of health care budgets, under the SIM Initiative such activities can be brought under the health care umbrella, potentially increasing apparent costs.

The SIM Initiative has, however, set a goal for value-based purchasing participation—specifically, 50 percent of Medicaid, Wellmark, and Medicare payments are to be linked to value-based purchasing contracts by 2018. Stakeholders considered this goal very achievable—value-based purchasing is already widely used in Wellmark and Medicare ACO contracts, and the new Medicaid MCOs are contractually obligated to grow their value-based purchasing participation over the next several years.

The SIM Initiative also includes two goals related to utilization that have positive implications for costs: (1) reduce the rate of preventable hospital readmissions by 20 percent in the Medicaid and Wellmark populations by 2018, and (2) reduce the rate of preventable ER visits by 20 percent in the Medicaid and Wellmark populations by 2018. Stakeholders expressed mixed opinions about these goals. Some felt they are ambitious but achievable with successful implementation of the SIM Initiative’s care coordination components (C3s and SWAN). Others were skeptical that there will be any measurable improvements in hospital readmissions and unnecessary ER visits in the SIM Initiative’s relatively short 3-year implementation period, given the initial delays in implementation. These individuals felt more confident in the SIM Initiative’s ability to move the needle on population health measures, given what they described as the state’s “good history” with successful tobacco and obesity programs.

Related to health care spending and use, the state’s recent transition to Medicaid managed care is intended to shift the Medicaid budget to a sustainable growth rate and improve health care quality and efficiency in the Medicaid program. But some stakeholders shared skepticism about these aims and felt that MCOs will achieve cost-savings, not by improving care delivery, but by cutting reimbursement to providers and restricting benefits. One stakeholder gave the opinion that Medicaid beneficiaries might even begin to use the ER more under Medicaid managed

care—reasoning that if their previous PCP is not in their MCO network, some individuals will go to the ER instead.

While it is too soon to know how the shift to Medicaid managed care will affect intended SIM outcomes over the next year, it is clear that any statewide SIM impacts during the SIM award will have been delayed by the introduction of Medicaid managed care and the changes it has made in Iowa’s health care market.

E.4.2 Care coordination

Iowa stakeholders all recognized the important role care coordination plays in an effective health system. Clinic-level care coordination is fairly common in the state. For instance, nearly all the Medicaid providers participating in the focus groups had experience with clinic-based care coordinators who target high-risk patients—such as those with certain conditions (e.g., diabetes) and comorbidities, or those with high health care utilization (e.g., many ER visits). Providers shared examples of the positive impact of care coordinators. One explained, “Our care coordinators call a patient as soon as they get out of the hospital. They try to get them into [the PCP office] within 3–5 days of discharge. A huge part of the reason patients go back to the hospital is that their medications get messed up after discharge...our care coordinators help.”

At the same time, Medicaid beneficiaries participating in the focus groups reported mixed experiences related to coordination between their PCP and other providers. Several beneficiaries noted that their PCP was not aware of the care or prescriptions they had received from a specialist. Many beneficiaries in the focus groups had visited the ER in the past year, and several of those reported that their PCP was unaware of the ER visit.

Several components of the Iowa SIM Initiative are focused on bolstering care coordination. The SWAN system’s purpose, for example, is to equip providers with actionable ADT data, so they can deploy individual-level care coordination resources and communicate with other providers as necessary. The C3s, in contrast, are focused on population care coordination, which is fundamentally different from service provided at the individual level. Population care coordination, as described by stakeholders, becomes an embedded skill that is an expected part of health care service delivery for all provider organizations, rather than an added service accompanied by enhanced reimbursement.

Stakeholders shared many expectations for the C3s and what they could achieve under the SIM Initiative. For instance, C3s can provide a structure that guides individuals in the community who would benefit from care coordination activities to an agency that can assist them. One stakeholder described this as establishing triggers in the community that will activate the process of connecting an individual in need to an organization or person who can help. C3s can also be a vehicle through which the health care community (providers, payers, community-based organizations) assesses community needs and the resources that exist to meet those

needs—ultimately identifying gaps or duplication in resources, so services available in each community become both more efficient and more comprehensive.

Most commonly, however, stakeholders described the C3s’ potential for fostering collaboration to achieve common population health goals. This includes collaboration among: (1) health care providers in different, historically soloed disciplines (e.g., behavioral health, acute physical health, community-based preventive care); (2) health and social service providers that serve many of the same patients/clients but have little awareness of one another; and (3) MCOs that are still learning about Iowa Medicaid enrollees and the state’s public health providers in the C3s who already know their communities very well. Regarding the latter, one stakeholder described the C3s as “free infrastructure” that will enable MCOs to fulfill their responsibilities as care managers.

Though the population health focus areas (diabetes, obesity, tobacco use) are common across the C3 communities, each coalition has created its own unique action plan and set of goals. Stakeholders described achievement of these goals as one marker of C3 success. Building capacity for collaboration that will continue beyond Award Year 4 is another. As one stakeholder summarized, “Success for SIM is leaving behind in communities a durable capacity that can be redeployed for other health improvement opportunities...part of that capacity is relationships at the local level, it’s positive experiences that people have working together.”

Despite high hopes for what C3s might achieve, stakeholders raised some concerns about the long-term sustainability of the SIM Initiative’s care coordination structures. As noted earlier, some worried that changes made under C3 grants will not be sustainable in the long term without an ongoing funding source. Others felt that the care coordination component of the SIM Initiative had been fast-tracked when the state modified its plans to accommodate the introduction of Medicaid managed care, and worried that care coordination structures are being built before it is clear how they will interact with or “fold into” an ACO structure. This presents the risk that the care coordination efforts will not be sustained if they have not been implemented in a way that is useful for ACOs.

Given the introduction of C3s within a small number of communities at a time, those initiatives, even if successful, are unlikely to have a significant effect on statewide estimates of SIM outcomes.

E.4.3 Quality of care

Many stakeholders said they view high-quality care as a strength of Iowa’s health delivery system. Nearly all the Medicaid beneficiaries participating in the focus groups had a usual source of primary care; and a majority expressed satisfaction with their care and felt it was high quality. One beneficiary explained, “My PCP is very precise. She explains what my medicines do, how they interact with each other, what to do in case of emergency. She’s very

informative. It's really important to have that kind of rapport.” Another spoke of how his nurse practitioner carefully reviewed age-appropriate preventive screenings during his annual physical, and followed-up with a referral for a colonoscopy. The most common negative experience was feeling rushed during appointments, which beneficiaries mostly attributed to overbooking and high demand for Medicaid-participating PCPs.

Though Medicaid providers participating in the focus groups described activities associated with high-quality, patient-centered care—including the use of care coordinators (as described above) and an emphasis on patient education—they also expressed concerns about what they viewed as the “depersonalization” of clinical care and its influence on quality. They related this to a growing number of documentation requirements for various health care programs and growing reliance on health IT. One summarized by saying, “The last few years have been overwhelming. You need to do this for Medicare, that for Humana, do the wellness forms, the medical home forms. A lot of time is spent on documentation.” Another added, “At one time the overarching goal was for patient-centered medical care but the pendulum has swung in the other direction now. It's completely dehumanized.”

The transformation to a value-based health care delivery system has obvious implications for quality of care; a value-based system bases health care payment on improved health outcomes, and good health outcomes are also the basis of health care quality assessments. Accordingly, stakeholders said they thought all SIM components—value-based purchasing, SWAN, C3s, and community-based performance improvement/technical assistance—have the potential to influence health care quality in a positive way.

More specifically, some stakeholders noted that the spread of value-based purchasing and use of the VIS (which incorporates a number of different quality measures) will naturally prompt providers to pay more attention to the quality of care they provide, to show their own value within the health care system. One provider stakeholder explained this as it relates to building an ACO: “At a provider level you have to start changing yourself if you want to survive in the future and be a viable partner when the ACO is knocking at your door. You want to be able to say here is what value we bring to your system instead of saying we *think* we do a great job.” Stakeholders also said they expect SWAN alerts to improve quality by helping providers to follow up with appropriate care after a hospital event, therefore increasing the likelihood of a good health outcome. And stakeholders described C3s as having the potential to spur collaboration between providers, so care is more continuous and holistic (rather than episodic). One stakeholder summarized the benefits of the combination of these components to support a value-based system by saying that under the SIM Initiative, health care services will be higher quality because they will become more “purpose driven.” Another expressed the feeling that the SIM Initiative is fostering development of a common language around health care quality among payers, providers, and public health.

The SIM Initiative’s success with respect to health care quality is closely tied to the expansion of value-based purchasing and to the achievement of goals to reduce preventable health events. Thus, delays in the introduction of value-based purchasing with the shift to Medicaid managed care make any observable evidence of improvements in quality of care during Award Years 2-4 less likely.

E.4.4 Population health

The Iowa SIM Initiative’s significant focus on population health is reflected in the governance structure (with IDPH playing a key role) and in the C3 awards (a majority went to public health departments). The SIM Initiative also includes learning communities and targeted community-based performance improvement/technical assistance focused on a set of IDPH-developed “Statewide Strategies” that relate to the key population health areas of tobacco use, diabetes, obesity, health literacy, elective deliveries, health care-associated infections, and adverse drug events. Many stakeholders view the SIM Initiative as a catalyst for connecting public health to the acute health care delivery system, and for moving the delivery system to a population health orientation that recognizes the critical role social determinants of health play in health care outcomes (and, consequently, in the transition to value-based purchasing). One stakeholder described this by saying that the SIM Initiative has the potential to elevate public health to a “chief health strategist” position within the health system, an atypical role for the state’s public health agency.

Prior to the SIM Initiative, providers at different levels were engaged in population health improvement activities via the CHNA&HIP process (described earlier) that has been conducted collaboratively at the county level for over two decades. The C3s, which also operate at the county (or multi-county) level, build on this foundation, bringing some of the same players to the table for a related purpose. Each C3 must include a focus on diabetes, obesity, and tobacco use in its action plan, and the SIM Initiative has set three statewide goals related to these areas:

- **Diabetes.** Increase the A1c test rate by 4.1 percent by 2018.
- **Obesity.** Decrease the prevalence rate by 2.9 percent by 2018.
- **Tobacco use.** Increase the quit attempt rate by 5.1 percent by 2018.

Medicaid beneficiaries in the focus groups commonly described discussing these three areas with their PCPs. Several were tobacco users and spoke about PCP referrals to the Quit Line and for smoking cessation services. Others said they discussed strategies for losing weight (including access to discounted or free gym memberships, changes to their diet, and portion control). Several indicated they feel supported by their PCP to make personal health improvements.

Most stakeholders pointed to achievement of the three statewide SIM goals as a marker of success for the SIM Initiative’s population health component. But they had mixed opinions about the goals themselves. Some felt they could have been more ambitious, and one stakeholder

described them as “a little dated,” particularly the goal on tobacco use. Others indicated that meeting the goals will be more challenging, since the state has already made improvements in many population health areas and—as one stakeholder put it—the “low-hanging fruit has already been accomplished.” Regardless, stakeholders agreed achievement of these goals would be very motivating for providers and the other community agencies that had been working on the goal. In addition, it might get the attention of payers to change their payment methodologies to facilitate the ongoing sustainability of the approach the community took to achieve the improved outcome.

Some stakeholders shared other ideas about success under the SIM Initiative’s population health component. For instance, some thought the SIM Initiative could strengthen and potentially sustain Iowa’s large rural hospital delivery system through its population health activities. A stakeholder from a rural county explained how a Critical Access–designated hospital had been a long-standing pillar in her community, but faced threats to long-term survival because of low volume and a shrinking population. Because of the SIM Initiative, that hospital is now working together with the public health department on preventive care initiatives, which she viewed as key to the hospital’s future.

However, delayed implementation of value-based purchasing and the limited scope of C3s to date make it less likely that there will be improvements in population health during Award Years 2-4 that can be attributed to SIM activities. However, since the SIM Initiative builds on existing population health initiatives in the state, stakeholders felt it possible those underlying efforts will move SIM’s population health goals going forward.

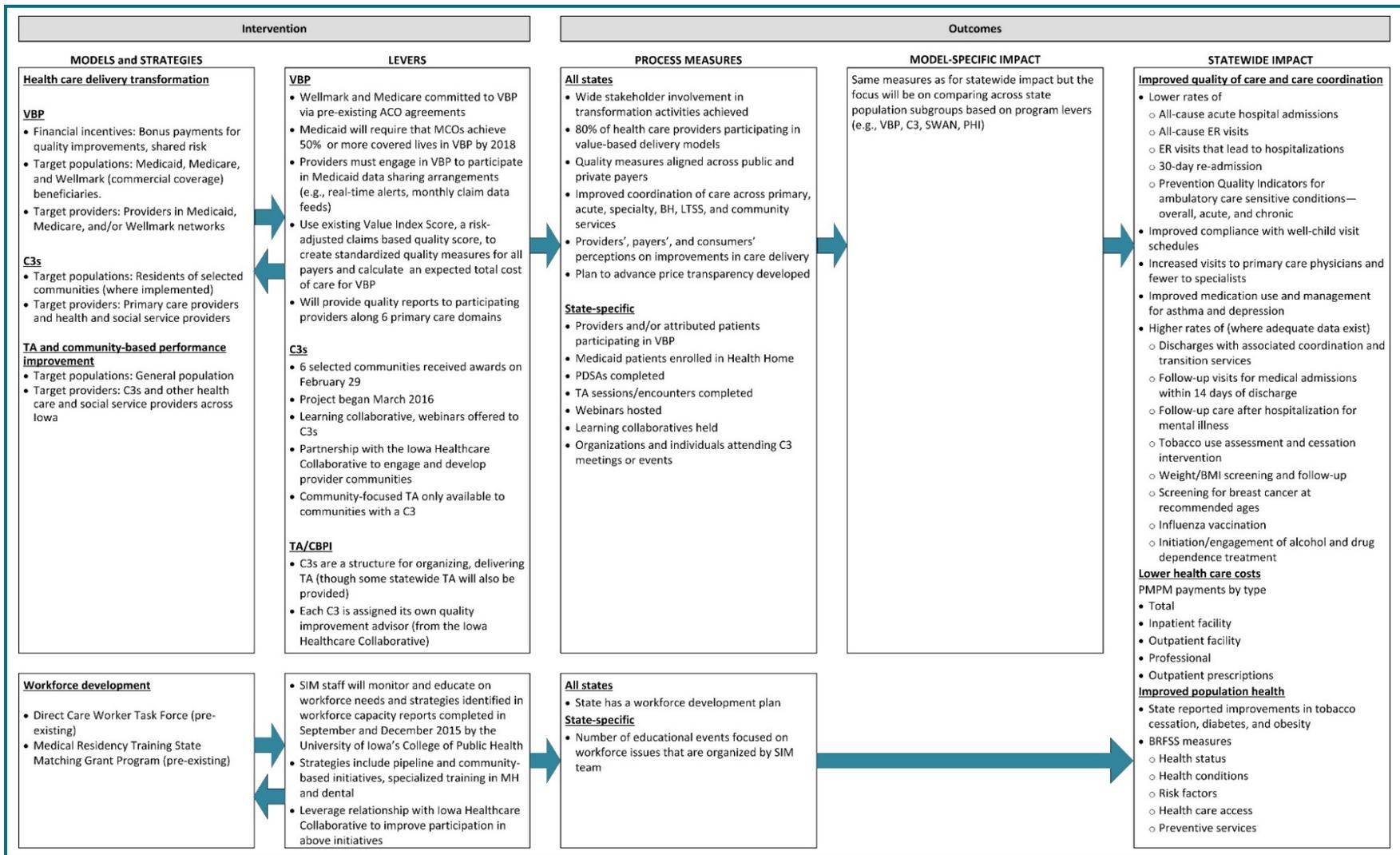
E.5 Overall Iowa Summary

Despite considerable challenges related to the introduction of Medicaid managed care and functioning within a dynamic health care environment, the Iowa SIM Initiative has met many operational milestones and succeeded in getting several major SIM components off the ground. For instance, as of the 2016 site visit, six C3 projects are operating across 20 counties; the SWAN system is dispatching thousands of alerts each month (including to five major ACOs); successful Learning Communities have been held, and more are being planned; a comprehensive approach to TA has been launched to support the C3s; and a series of evidence-based statewide strategies for improving population health have been developed and are being disseminated. Value-based purchasing requirements are included in the state’s contracts with Medicaid MCOs, complementing the already well-established value-based purchasing arrangements used by the other payers the SIM Initiative targets (Wellmark and Medicare). Though still in early stages, the VIS is being modified so that it better fits the needs of all payers that will use it. The Iowa SIM Initiative has made progress on many fronts, and benefits from a fairly concentrated health care market and a history of collaboration within the health care system. Moreover, nearly all stakeholders agreed with the SIM Initiative’s goals—though they shared mixed opinions about how ambitious or achievable they are in a short 3-year timeframe—and approved of the state’s overall approach to health care system transformation.

At the same time, the Iowa SIM Initiative is operating in an environment stakeholders described as having many future “unknowns” that threaten, or at least complicate, achievement of its overarching purpose—fostering community-based collaboration among payers, providers, and public health entities to address population health needs and create a more sustainable health care delivery and payment system. These future unknowns include ongoing uncertainties in the health care market related to the recent recession and the ACA, and—most significantly—the implications of the shift to Medicaid managed care.

The Medicaid MCOs represent the primary lever for achieving the state’s goals for expansion of value-based purchasing (perceived to be the key driver for long-term system change) across Medicaid. Yet across the board, stakeholders shared a number of concerns about the introduction of managed care and what they perceived as its negative impact on SIM implementation. With Medicaid MCOs operating for less than 2 months at the time of the site visit, it is impossible to assess what the true effects of this change have been for the Iowa SIM Initiative, although it has clearly delayed SIM activities. Future qualitative data collection will monitor this aspect of Iowa’s project closely in addition to studying the continued implementation of the major SIM components and progress towards the SIM Initiative’s goals.

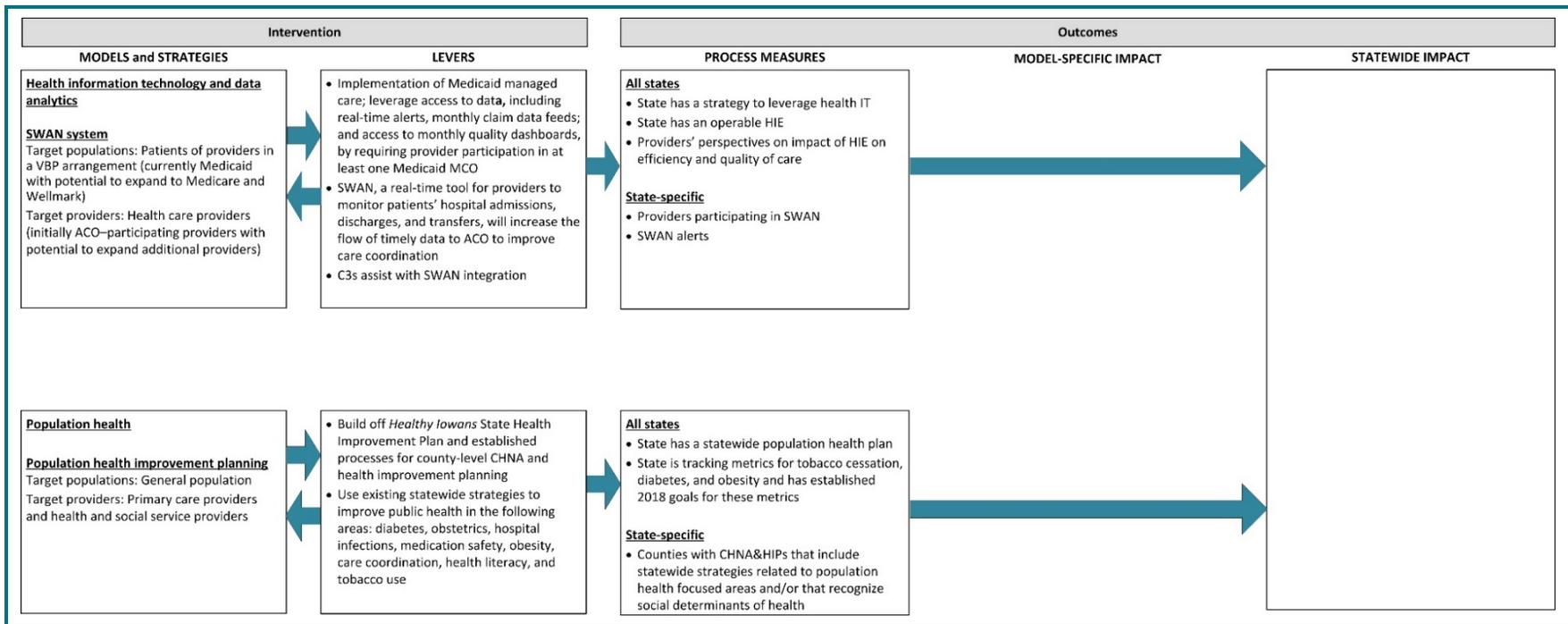
Figure E-1. Logic model for Iowa's State Innovation Model activities



E-26

(continued)

Figure E-1. Logic model for Iowa’s State Innovation Model activities (continued)



E-27

ACO = accountable care organization; BH = behavioral health; BMI = body mass index; BRFSS = Behavioral Risk Factor Surveillance System; C3 = Community Care Coalition; CBPI = community-based performance improvement; CHNA = Community Health Needs Assessment; CHNA&HIP = Community Health Needs Assessment and Health Improvement Plan; ER = emergency room; health IT = health information technology; HIE = health information exchange; LTSS = long-term services and supports; MCO = managed care organization; MH = mental health; PDSA = Plan-Do-Study-Act; PHI = protected health information; PMPM = per member per month; SIM = State Innovation Model; SWAN = Statewide Alert Notification (Iowa); TA = technical assistance; VBP = value-based payment.

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Appendix F: Michigan Site Visit Report

During the 2016 site visit, the RTI team conducted 17 in-person key informant interviews in Lansing, Flint, and Jackson, Michigan from May 9 through May 11. The interviews focused on the context of the state’s health care system and early SIM implementation successes, challenges, and lessons learned. Interview participants included state officials from state agencies or departments and representatives from payers and purchasers, consumer advocate organizations, and provider organizations involved in the development and implementation of Michigan’s SIM Initiative.

The RTI team also conducted provider and consumer focus groups in Flint and Jackson on June 15 and 16, 2016. The team spoke with providers to learn about their experiences with the current health care system in the state and their awareness of the Michigan SIM Initiative. The team spoke with Medicaid beneficiaries with at least one chronic condition who had visited their primary care provider (PCP) at least once in the prior 12 months, to learn about their experiences getting care.

This appendix provides an overview of the Michigan SIM Initiative, including its major activities; describes the current health care context in which Michigan is implementing the SIM Initiative; summarizes major early implementation successes, challenges, and lessons learned; and discusses key findings from the site visit interviews and focus groups, organized by topical area. This appendix includes findings based on qualitative data collected through June 30, 2016. Further details on the analytic approach are available in *Appendix L*. Information on the site visit interviewees for the state is in *Table L-1*, and information on the provider and consumer focus group participants for the state is in *Tables L-4* and *L-5*, respectively.

F.1 Overview of Michigan’s State Innovation Model

The Michigan SIM Initiative builds on the Governor’s 2014 vision for “healthy, productive individuals, living in communities that support health and wellness, with ready access to [an] affordable, patient-centered and community-based system of care.” This is the core tenet of the state’s Blueprint for Health, the product of Michigan’s SIM Round 1 Model Design award.⁴⁴ The SIM Initiative aims to improve patient care (including quality and patient experience), reduce per capita cost of care, and improve population health. To achieve these aims, Michigan plans to implement three major initiatives.

- ***Patient-centered medical homes (PCMHs)***. PCMH, a care delivery model whereby a patients’ treatments are coordinated through their PCP, will be the core pillar of the SIM Initiative’s health care delivery system reform strategy.

⁴⁴ State of Michigan. (2014, January 24). *Reinventing Michigan’s health care system: Blueprint for health innovation*. Retrieved September 7, 2016, from http://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_64491_76091---,00.html

- ***Accountable Systems of Care (ASCs).*** ASCs are Michigan’s variant of accountable care organizations (ACOs). In ASCs, health plans and providers will earn bonuses if they control spending growth, while also meeting quality metrics. Managed care plans will be required to contract with ASCs, and ASCs will need to include PCMH practices in their provider networks.
- ***Community Health Innovation Regions (CHIRs).*** CHIRs are an especially innovative feature of the Michigan SIM Initiative. They will work with ASCs and health care providers to facilitate quality improvement and reductions in expenditures, by linking clinical resources with community-based social services. These regional entities will identify local health needs and support integration between health and other community-based services. Each CHIR will be linked to a “backbone organization,” which will be responsible for convening stakeholders, facilitating discussions, and supporting CHIR activities. Ultimately, CHIRs are designed to address the social determinants of health to improve overall wellness, including both health and non-health issues.

These three initiatives will be supported through:

- ***Alternative payment methods.*** Michigan plans to utilize alternative payment methods to encourage the processes necessary to achieve SIM goals. At the time of the 2016 site visit, the specific alternative payment methods were not fully established or disseminated to providers, but all interviewees said they expected ASC incentives to be based on a shared risk/shared savings model, as is common in other ACO models.
- ***Performance metrics.*** The state plans to collaborate with payers and providers to establish a set of common performance metrics that will be linked to alternative payment methods and used to measure progress.
- ***Health information technology (health IT).*** Interviewees described health IT as a critical component of the SIM Initiative. Michigan is working to leverage existing health IT capacity—e.g., the Michigan Health Information Network (MiHIN), the state’s health information exchange (HIE)—to facilitate performance metric collection and reporting, effective care coordination, and technology to support population health efforts.

By the time of our site visit, Michigan had made two major decisions related to SIM implementation.

First, Michigan planned to implement the SIM Initiative in five regions of the state—Jackson County, Genesee County, Muskegon County, Washtenaw and Livingston Counties, and Northern Michigan (a largely rural area composed of 25 counties)—to make the implementation process more manageable. These five areas were selected, from 14 that had applied to the state to be part of the SIM Initiative, because they offered state officials a diverse mix of circumstances under which to test the SIM Initiative. For example, some regions have sophisticated health and community systems ready to move forward on all components of the SIM Initiative, while others will need more development. The five regions also provide a mix of urban, suburban, and rural

communities, to provide experiences implementing the SIM Initiative in different types of communities.

Second, the state decided to focus SIM activities on Medicaid beneficiaries and Medicaid managed care plans, as opposed to involving additional payers.

F.2 Logic Model

Figure F-1, located at the end of this appendix, is a logic model of Michigan’s SIM Initiative, depicting the hypothesized relationship between specific elements of the state’s SIM Initiative and changes in outcomes. Column 1 describes the models and strategies Michigan is pursuing with its SIM funds. Column 2 describes specific policy levers the state is contemplating to implement these models and strategies. The remaining columns identify the expected impacts of SIM activities. Column 3 primarily identifies process measures CMS and the state hope to influence through Michigan’s SIM Initiative (e.g., getting 80 percent of health care providers to participate in value-based delivery models). Column 4 identifies specific outputs expected to be achieved through the state’s core SIM activities: development of CHIRs supported by PCMHs and ASCs. Column 5 identifies statewide patient outcome measures CMS hopes to influence in all SIM Round 2 Model Test states (e.g., lower rates of all-cause emergency room [ER] visits, lower health care costs per member per month [PMPM]).

F.3 Implementation Activities

This section discusses the existing health care infrastructure in Michigan and how the SIM Initiative will fit within the current landscape. It also describes the governance structure for the department implementing the SIM Initiative and provides an overview of the stakeholder engagement process during the planning and early implementation phases of the SIM Initiative. Finally, it describes how the state is utilizing payment reform and health IT to support SIM activities, as well as early lessons learned from the perspective of state officials and other SIM stakeholders.

F.3.1 Context of health care system

The Michigan SIM Initiative builds on years of health system improvement efforts in the state. State officials widely acknowledge the need for further change, however, which was the motivation for developing the *Blueprint for Health*.⁴⁵ Major population health problems identified as needing improvement include infant mortality, adult obesity, hypertension, cardiovascular disease, cigarette smoking, and veterans’ access to health care.

The private sector and state government have both collaborated and worked independently on health reforms that pre-date but influence the SIM Initiative, with a particular

⁴⁵ State of Michigan. (2014, January 24). *Reinventing Michigan’s health care system: Blueprint for health innovation*. Retrieved September 7, 2016, from http://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_64491_76091---,00.html

focus on the PCMH model. The prior initiative most often mentioned by stakeholders as important to the SIM Initiative is the Michigan Primary Care Transformation (MiPCT) project, which is described in more detail below. Other initiatives in Michigan viewed as part of the foundation upon which SIM is to be built include:

- ***The Michigan Children’s Health Access Program (MiCHAP).***⁴⁶ MiCHAP is a community-based pediatric medical home model implemented in nine counties, several of which overlap with counties where initial SIM implementation is under way (Genesee County and some Northwest Michigan counties).
- ***The Physician Group Incentive Program (PGIP).***⁴⁷ PGIP is another medical home practice transformation program that Blue Cross/Blue Shield (BCBS) of Michigan has supported for over 10 years.
- ***MiHIN.*** MiHIN is the state’s HIE established in 2010. Years of work trying to improve health care through the medical home model and enhanced application of technology through the HIE infrastructure set the stage for the SIM Initiative by providing some of its fundamental elements.

In addition to these prior efforts, concurrent activities interact with, and could affect, the SIM Initiative. The State Health Needs Assessment and corresponding State Health Improvement Plan cover 2012 through 2017. Developed by the Michigan Department of Community Health (MDCH) (later renamed the Michigan Department of Health and Human Services [MDHHS]) during the SIM Round 1 Model Design phase,⁴⁸ the development of the State Health Improvement Plan was a collaborative effort with many stakeholders—including for-profit and not-for-profit organizations, health care providers, local governments, and academics; as well as faith-based, community-based, and consumer organizations and individuals. The State Health Improvement Plan, which is based on an extensive statewide health needs assessment, outlines the state’s major public health priorities as the following: promotion of healthy behaviors, reduction of obesity, decreased substance and tobacco use, and promotion of mental health. The SIM Initiative intentionally builds around these focal areas, and will realign its priorities with the state’s new State Health Improvement Plan when it is drafted and comes into effect in 2017.

Before the SIM Initiative, medical home providers received payments through a variety of strategies. The most widespread, and the one discussed most often in the context of the SIM Initiative, is MiPCT—a 5-year demonstration testing the value of the PCMH model in expanding access to primary care while improving care coordination. As part of the CMS Multi-Payer

⁴⁶ Michigan Association of United Ways. (2016). *Michigan Children’s Health Access Program*. Retrieved July 25, 2016, from <http://www.uwmich.org/michap/>.

⁴⁷ Blue Cross Blue Shield. (2016). *About the Physician Group Incentive Program*. Retrieved April 20, 2016, from <http://www.bcbsm.com/providers/value-partnerships/physician-group-incentive-prog.html>.

⁴⁸ Michigan Department of Community Health. (2012, August 16). *Michigan’s State Health Assessment and State Health Improvement Plan: 2012–2017*. Retrieved September 7, 2016, from https://www.michigan.gov/documents/mdch/MDCH_SHIP_FINAL_8-16-12_400674_7.pdf.

Advanced Primary Care Practice (MAPCP) demonstration beginning in 2012, MiPCT included Medicare, Medicaid Health Plans, BCBS, Blue Care Network, and Priority Health (another large Medicaid managed care organization [MCO] in the state). Participating payers funded the medical home activities of Physician Organizations (POs), Physician Hospital Organizations (PHOs), and primary care practices through care coordination payments, practice transformation payments, and performance incentive payments. Predating MiPCT is the BCBS PGIP, which began in 2005 and has supported practice transformation by rewarding POs for improved performance on care delivery metrics. MiPCT and PGIP have overlapped with SIM planning, and influenced the timelines of the PCMH roll out. MiPCT will continue until the end of 2016, and the SIM Initiative’s PCMH efforts will launch on January 1, 2017, to prevent a lapse for existing PCMHs. Rather than be in competition with these efforts, the SIM planning process has factored in the extent of PCMH work already accomplished by MiPCT and plans to use that base to expand the network of PCMHs in Michigan.

Additionally, at the time of the 2016 site visit, the state and its providers were still trying to understand the implications of other evolving federal demonstration programs. During the site visit, questions surfaced about how the Comprehensive Primary Care Plus (CPC+) medical home model, announced by CMS in April 2016, might affect the SIM Initiative.⁴⁹ Beginning in 2017, this 5-year demonstration will focus on care delivery and payment in Advanced Primary Care settings. Given Michigan’s focus on this area through its PCMH program, the state is in the process of figuring out how to avoid conflicts and increase alignment between the SIM Initiative and CPC+.

Interviewees raised three other contextual elements that may also impact implementation of the SIM Initiative. The most often mentioned contextual factor was the need to re-bid Medicaid managed care plan contracts in fall 2015, the same time planning was under way for the SIM Initiative. The state stopped all communication with stakeholders about the SIM Initiative while this contracting process was under way, to avoid influencing the contents of the managed care plans’ proposals, especially as they related to ideas about alternative payment models (APMs). This prolonged pause—which stakeholders said they viewed as a “radio silence” following months of active engagement with the state—led the state to seek a no-cost extension to its SIM funding. Its approval enabled Michigan to delay the official launch of the SIM Initiative until August 2016.

The second major contextual factor is the Flint water crisis. The amount of work required to address the lead in Flint’s water system has redirected the time and energy of many state staff who would otherwise have been involved in the SIM Initiative. While some stakeholders agreed

⁴⁹ Although CPC+ regions had not been announced at the time of the site visit, Michigan was considering how the model would impact them, if they were selected as a region.

that the SIM Initiative could provide an opportunity for health improvement in Genesee County, where Flint is located, the SIM Initiative is not viewed as a central focus in that region.

Third, as is likely the case in most or all other states with SIM Initiatives, stakeholders noted concern that the sheer number of state and federal initiatives, such as CPC+, will affect the ability of the state, providers, payers, and other stakeholders to take on yet another reform program. Interviewees described this as a challenge, but not one that is insurmountable.

F.3.2 Governance and program administration

The SIM Initiative is run out of MDHHS. A high-ranking MDHHS official serves as program director and oversees the work of the four major groups governing the SIM Initiative: population health, delivery system, health IT, and project management and governance. Below the program director, another state official serves as program lead for SIM program management and governance and is the day-to-day operational lead for the SIM Initiative. While at the time of the 2016 site visit, MDHHS said it has sufficient financial resources to carry out the SIM Initiative, it also said it was understaffed and in the process of hiring for multiple key positions. MDHHS also enlisted the help of numerous contracted organizations—including the Michigan Public Health Institute, Bailit Health Purchasing, Health Management Associates, and the Institute for Healthcare Improvement (IHI).

Work groups and task forces play an important role in the SIM Initiative, by facilitating external input and collaboration, and by providing guidance on development of the SIM Operational Plan. In April 2013, MDCH formed the SIM Advisory Committee, which consisted of representatives from payers, state agencies, businesses, consumer groups, providers, community service entities, and academia. That committee met monthly to create detailed specifications for SIM activities.

After receiving the Round 2 Model Test award, the state again formed subject matter work groups to build the framework of the Operational Plan, such as the Patient-Centered Medical Home and Accountable Systems of Care work groups. Committees have also been created, including the Care Delivery, Population Health, and HIE/Health IT Committees. As a result of this approach, many stakeholders have been involved and expressed feeling able to actively participate in the process. Even so, some said they believed state officials had already decided what they wanted to do and were only involving them as a formality.

F.3.3 Stakeholder participation

Beginning in the Model Design phase, Michigan has formally included a wide spectrum of stakeholders in its planning and decision-making processes. Among these have been several key organizations and groups.

Among payers, BCBS is the largest commercial insurer in the state, with between 60 and 70 percent of the commercial market. BCBS also serves individuals and families covered under Medicaid and the Healthy Michigan Plan through an MCO called Blue Cross Complete. BCBS was directly engaged through numerous meetings along with other stakeholders and participants in the planning process. Michigan sought to understand BCBS's payment model in an effort to create multipayer alignment and extend the impact of the SIM Initiative. After the SIM Model Test application was submitted, BCBS leadership travelled with state employees to present the request to CMS. In addition to BCBS, other Medicaid MCOs have played a role in SIM development, which stakeholders described as essential to implementation. The state encouraged their participation by using its MCO contracting process to allow plans to suggest payment methods that could potentially feed into the value-based approaches the SIM Initiative is aiming to encourage. One way the state did this was by considering at-risk payment arrangements as positive factors in an MCO's bid.

A second key stakeholder group consists of major health systems, including POs and PHOs—the types of groups likely to form the ASCs. POs, which are common in Michigan, are otherwise independent physicians who form a group to centralize certain administrative functions. PHOs are groups of physicians linked to hospitals in an organization that performs administrative functions for both physicians and hospitals. PHOs started to become common throughout the state in the 1980s, and now are critical stakeholders for programs like the SIM Initiative. PO and PHO representatives have been involved since the SIM design process and throughout the development and implementation of the SIM Initiative, through formal participation in the advisory committee and in work groups. Jackson Health Network, for example, helped the state develop the ASC and CHIR concepts and also travelled to Washington, DC to help present the Model Test request to CMS. This level of inclusion did not extend to most stakeholders, however, with numerous groups feeling as if their participation was limited in scope.

To create broader engagement outside the advisory committees and work groups, Michigan held a series of large group meetings and webinars for interested parties, and made implementation documents available for written public comment. The largest challenge to stakeholder engagement to date has been the MCO rebid period of “radio silence” on SIM communication described above, which many stakeholders said contributed to a loss of SIM momentum. After the contracting process was completed, the state resumed its activities and continued with its planning process through the work groups. This included the state hosting a series of public webinars throughout April and May 2016, which gave an overview of the SIM Initiative and provided detail on CHIRs, the Collaborative Learning Network (CLN, see below), and PCMHs.

F.3.4 Delivery systems and payment reforms

In the *Blueprint for Health Innovation*,⁵⁰ Michigan outlined its plan to create payment reforms that paid for value instead of volume and incentivized PCMHs, ASCs, and CHIRs to undertake delivery reforms that would support SIM goals. Since then, Michigan has added CLN to its CHIR implementation. Michigan is contracting with the IHI to develop the CLN, which will enable shared learning and lesson sharing across SIM participants and regions, and include in-person shared learning opportunities as well as more individualized coaching. The in-person meetings are designed to facilitate interaction across regional groups that might not otherwise interact. The CLN promises to: (1) build capacity for ongoing cross-regional relationship building; and (2) create a sustainable infrastructure for shared goal setting, outcome tracking, and lesson sharing, during and after the SIM Initiative. The CLN's structure and content will be participant-driven, to be sensitive to the shifting needs of participants over the course of the SIM Initiative.

The SIM Initiative's proposed payment reforms have evolved over the past several years. Michigan initially intended to include models such as bundled payments or episodes of care. But the state has put that aspect of the SIM Initiative on hold while focusing on the details of PCMH, ASC, and CHIR implementation. As part of this process, Michigan built alternative payment into its ASC and PCMH models as part of its goal to align payment incentives with outcome goals.

While full implementation details were not final at the time of the 2016 site visit, the state outlined its vision for value-based payment (VBP) through PCMHs and ASCs in its draft Operational Plan: "Improvements in provider behavior within Patient-Centered Medical Homes and Accountable Systems of Care will be rewarded through provider participation in shared savings or two-sided risk models, respectively, care coordination payments and practice transformation funding." State officials echoed this sentiment during the 2016 site visit when discussing ASCs and PCMHs as methods of both payment and delivery system reform.

Because SIM payment reforms were not firmly in place at the time of the 2016 site visit, how MCOs are going to pay ASCs and how any shared savings that emerge will be distributed between the MCOs, ASCs, and possibly PCMHs remained uncertain. To the extent that payments to PCMHs are an extension and expansion of existing payment models, payers and providers anticipate little disruption and generally anticipate a smooth and positive transition. However, stakeholders expressed concern about other aspects of payments under the SIM Initiative still unknown.

⁵⁰ State of Michigan. (2014, January 24). *Reinventing Michigan's health care system: Blueprint for health innovation*. Retrieved September 7, 2016, from http://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_64491_76091---,00.html

F.3.5 Health information technology and data infrastructure

Michigan plans to use MiHIN—its “network of networks”-style HIE—to support SIM implementation. MiHIN was launched in 2010 through the federal Health Information Technology for Economic and Clinical Health program. MiHIN connects eight regional HIEs and manages the requisite data use agreements (DUAs) to facilitate secure and efficient exchange of health information throughout the state. Once an organization has met the technological and security requirements to participate in MiHIN, it is considered a qualified organization (QO). Providers, provider groups, payers, pharmacies, health departments, and consumer organizations can become QOs and join MiHIN. As a requirement of participation in MiHIN, QOs must carry out DUAs and participate in use cases as directed.

Michigan articulated four important areas of data and technology use in the SIM Initiative: (1) performance monitoring and reporting, (2) care coordination, (3) payment model analytics and reporting, and (4) population health. To enable performance monitoring and reporting, Michigan is planning to build a data aggregator and is consulting with the Michigan Data Collaborative, which has functioned as a data aggregator for MiPCT. To enable care coordination, Michigan is planning to expand MiHIN use—especially through admission, discharge, and transfer (ADT) notification, and active care relationship (ACR), like patient attribution in other states’ use cases. How the state will enable payment model analytics and reporting is not fully developed, because the state has not yet released information about a new payment model, as noted. To enable population health, Michigan plans to use MiHIN to help track a broad set of population health metrics, to inform ongoing needs assessments and to enable coordination among CHIR participants.

MiHIN’s widespread use among providers and the established system of DUAs provide a tested and promising platform for the SIM Initiative. Many stakeholders and state employees expressed strong feelings that data use and exchange would be integral to SIM Initiative success. At the state level, SIM staff were optimistic about their ability to use and expand existing data systems to meet SIM Initiative needs. But some community stakeholders, although in agreement about the importance of health IT, expressed concern that the entry and transmission of data are not yet widespread or user-friendly enough to realize the full potential of MiHIN and the SIM Initiative’s greater technology goals. For example, a health plan representative commented that data-sharing capabilities between providers and health plans is “far away from where it should be.” The same stakeholder noted that MiHIN has potential to transform data sharing in the state, but that many providers and health plans are not yet prepared to supply the data MiHIN requires.

Along with PCMHs, health IT is an area where the SIM Initiative is building on prior efforts. The BCBS PGIP financially incentivizes providers to participate in two use cases in MiHIN: ACRs and ADT notifications. Michigan hopes to expand the use of both these cases, to help map patients to their provider(s) through the ACRs, and to enable care coordination

between hospitals and community-based providers through ADT notifications. The state is also building on MiPCT through consultation with the existing data aggregator for that program.

F.3.6 Workforce development

Currently, no part of the Michigan SIM Initiative is directed at workforce development. Some providers indicated a pent-up demand for certified community health workers (CHWs), and expressed the hope that the SIM Initiative would help fund the education and certification of this increasingly important provider type.

F.3.7 Technical assistance and other support resources

According to SIM leadership, Michigan's experience with CMS and CMMI staff has "been incredible." Michigan leadership described having received rapid, responsive, thoughtful help from CMS. Through its support contract with CMS, the state not only engaged a number of contractors for TA; state officials also said their experience with these contractors has been largely positive in providing Michigan with knowledge and assistance beyond the capacity of internal staff.

F.3.8 Progress, challenges, and lessons

Although Michigan had not yet launched its SIM Initiative at the time of the 2016 site visit, both state employees and community organizations reported they have already made significant progress in engagement and planning, and have learned lessons from successes and challenges alike. Community stakeholders repeatedly emphasized the importance of communication, both among one another and with state government. The extent of stakeholder involvement in the planning process was reportedly important to the viability of the plan, and helped shape a vision of the SIM Initiative that aligned with the realities of care delivery and payment in the state.

However, the "radio silence" during the Medicaid rebid, as noted, created a significant challenge. Stakeholders had been eager to begin implementing elements of the SIM Initiative and expressed frustration with the ensuing delays. State officials said they are aware of these frustrations and acknowledged the problems the protracted planning process caused. Despite delays, however, all stakeholder entities appeared organizationally ready to begin participating in the SIM Initiative by the time of the 2016 site visit.

As noted, both state officials and other stakeholders reported that building on extant work and infrastructure has been critical in facilitating the SIM involvement of major payers and providers and achieving an anticipated efficient, successful SIM launch. Multiple interviewees described the transition from MiPCT to PCMH, and the use of existing community networks to create CHIRs and ASCs, as wise decisions that will enable smooth implementation. State officials and other stakeholders interviewed almost uniformly agreed that the CHIRs are the aspect of the SIM Initiative with the greatest potential to have a significant effect on population

health, and that health IT use and improvement will be critical to CHIRs' success. Michiganders saw CHIRs as having so much to offer, because they build upon established organizations and networks, while also adding funding and a framework for new efforts to improve community health and access to social services. However, stakeholders widely agreed that there was greater certainty around the success of PCMH expansion, due to the large base of PCMHs already created by MiPCT and the willingness of payers to fund medical home development and activities

In an initiative of this scope and ambition, having appropriate resources is essential to success. Financially, Michigan's SIM award reportedly provides sufficient funding for the required planning and implementation efforts. The state government has created and filled multiple staff positions, and is building its capacity to have sufficient human capital to achieve its goals.

F.4 Statewide Changes

F.4.1 Health care expenditures

Reducing health care expenditures is one of the central aims of the SIM Initiative, and interviewees said they believe payment reform under the SIM Initiative represents an opportunity to meaningfully affect expenditures while improving patient experience (including health care quality) and health outcomes. Interviewees tended to focus on bending the cost curve in the context of the Triple Aim⁵¹—improving population health and quality of care while reducing cost. The state has identified three target populations for the SIM Initiative: (1) healthy mothers and babies, (2) individuals with multiple chronic conditions, and (3) high emergency room (ER) utilizers. All five SIM regions in the state will be required to concentrate on high ER utilizers initially, and expand their focus to include the other two target populations in later SIM years.

The most significant change in the SIM Initiative aimed directly at controlling health care spending is the movement to VBP for ASCs. As incentives, ASCs will have the opportunity to participate in shared savings or shared risk payment models.

Michigan will measure its progress toward achieving reduced growth in per capita cost of care by monitoring Cesarean section rates, hospital admissions, all-cause admissions, ER visits, and standardized PMPM costs. Additionally, as part of the SIM Initiative, Michigan is aiming to determine the “unit cost” for CHIRs, to more effectively evaluate the cost-effectiveness of these strategies.

Given the relatively short timeframe of the SIM implementation and test period, state officials acknowledged that it will be difficult to bend the cost curve, and that they might not see

⁵¹ Berwick, D. M., Nolan, T. W., & Whittington, J. (2008). The triple aim: Care, health, and cost. *Health Affairs*, 27(3), 759–769. doi: 10.1377/hlthaff.27.3.759

significant reductions in expenditures during the SIM award. However, they expressed optimism that the SIM Initiative has the potential to implement structures and processes that will ultimately achieve significant cost savings.

F.4.2 Health care utilization

Interviewees discussed suboptimal health care utilization in term of underuse of primary care and overuse of the ER. The SIM Initiative’s focus on the PCMH model of care encourages appropriate utilization of care through increased access (e.g., night and weekend hours), so patients are less likely to present at urgent care or the ER, increased preventive care (to avoid hospitalization in the first place), and patient education (about when to use or not use the ER). Additionally, the SIM Initiative, as noted, will give PCMHs and ASCs incentives to optimize health care utilization through VBPs.

Many providers in focus groups described “overutilization and abuse of the system”—as exemplified by unnecessary ER use, and the trend toward getting care at urgent care clinics instead a patient’s primary care clinic—as worrisome, but they hypothesized it could be mitigated by improving access at the primary care clinics (e.g., because some patients are currently using urgent care on weekends or after hours). Providers were concerned about how urgent care and ER use is threatening continuity of care, and some noted they are already trying to make it easier for patients to contact someone at the office at any time of day, in efforts to discourage urgent care use.

F.4.3 Care coordination

Michigan is relying on care coordination as a fundamental strategy to support the SIM Initiative transformation specifically related to its PCMH element, given the well-developed foundation of PCMHs throughout the state. Within the PCMHs, care coordination will be a major focus, both between PCPs and specialists, and between primary care and other community-based services. This integration within and across practices will rely heavily on health IT, and each practice’s ability to communicate seamlessly to share information about patients.

Patients in focus groups reported mixed experiences with care coordination in recent years. Some patients admitted to the ER expressed confidence that their PCP was aware of those circumstances (several said they received a phone call from their doctor’s office after release). Others expressed frustration that their health care providers, including primary care and specialists, did not seem to communicate with each other. A related issue is that some patients reported seeing a different provider each time they visit their primary care practice and that, even within the same system, providers are unaware of their medical history.

At the same, providers in focus groups reported that they spent increasingly more time over the past few years communicating with specialists and other providers about individual

patients. Some providers reported relying more and more on electronic health records to support this type of care coordination. Others are resisting transferring to an electronic system, and still communicating through fax or paper records. Some clinics said they had already hired care coordinators (including registered nurses, according to focus group participants)—who are aware of the SIM Initiative and perceive their role as improving care coordination for all patients (including contacting them for appointments, communicating with specialists, and following up with patients after they visit other providers).

F.4.4 Quality of care

Michigan is aiming to systematically improve quality of care, and ASCs will play a major role in these efforts if things go according to plan. In ASCs, PCPs and other key providers will work together to deliver efficient coordinated care. ASCs will also: (1) help facilitate quality measurement, data sharing, and communication to enable improvements in quality of care; and (2) be required to hold PCMHs and providers accountable for improving care delivery and quality.

Leading up to SIM implementation, the Michigan State Medical Society and MiHIN convened payers and physician groups to launch a conversation about quality metric reporting. The list of measures that emerged from those meetings originally included 27 distinct quality measures, with two more later added to reflect SIM priorities. As described above, quality measurement remains a critical SIM component. To track progress in quality of care improvement, the state has developed metrics and accountability targets related to SIM participation, clinical measures, population health measures, and measures of utilization and quality of care.

Focus groups with Medicaid beneficiaries yielded insights into the level of patient satisfaction with care before SIM implementation. Patients were fairly evenly split in describing positive or negative perceptions of their providers. Patients with positive experiences of care appreciated that their providers seem concerned about their health and personal lives and are generally accessible (e.g., a handful of patients mentioned they had their PCP's personal phone number, though no one reported having ever used it). These patients also said their providers are helpful in setting up appointments with specialists if necessary.

The most common criticisms among those who had negative experiences were that wait times for appointments are unnecessarily long (some said they spent up to two hours in the waiting room), time actually spent with providers is limited, it is often difficult to make an appointment (some expressed frustration with phone trees and long periods of time spent on hold), and care does not feel “personal.” Several patients mentioned they feel “like a number” at the doctor's office, and that their needs are not being met. On a similar note, some patients asserted that even while their doctors are ostensibly listening to them, they are not fully engaged in listening to their specific needs. For example, several patients expressed frustration that they

have to repeat their personal histories each time they see their provider. A handful of patients who were displeased with their care reported that they contacted their insurance company and were successful in resolving their respective issues (for example, by being assigned to a new provider).

F.4.5 Population health

What many interviewees described as the most innovative element of the Michigan SIM Initiative—the CHIRs—are designed to positively impact population health. As described above, CHIRs will leverage existing infrastructure by bringing together clinical and nonclinical social services resources to better meet patient needs. CHIRs will focus on social determinants of health, including housing and nutrition needs, to support improved health and wellness.

This element of the SIM Initiative will require close integration between agencies and organizations that may have had only limited interaction in the past, and represents a fundamental shift in the way some communities are thinking about health care. Interviewees emphasized that CHIRs will bring together entities that might otherwise duplicate efforts. Closer alignment of these historically competitive entities was described as creating efficiencies and also representing an opportunity to reduce expenditures. However, since Michigan is planning to implement the SIM Initiative by focusing on Medicaid beneficiaries, the potential for improvements in population health may be somewhat limited.

As described earlier, each CHIR will focus on improving outcomes for three SIM priority populations: ER superutilizers, healthy mothers and babies, and individuals with multiple chronic conditions. CHIRs will also conduct, or build on existing, Community Health Needs Assessments to identify other priority populations in their regions.

A “Backbone Organization” will be linked to each CHIR. This organization will convene CHIR members for meetings and facilitate the collaborative work processes. CHIRs are intended to build on existing infrastructure in each SIM region and will include a number of “required” participants, as well as nonrequired stakeholder types. Required participants include community members, local public health department(s), ASCs and other providers, community mental health service providers, Medicaid health plans, and other payers. CHIRs may also include representatives from the following stakeholder groups, organizations, or sectors: business, health care not included above, human services, philanthropy, local government, community and economic development, community safety and corrections, education, housing, transportation, state government, and other nonprofit types (e.g., civic centers, advocacy organizations, community-based organizations, and research institutes).

The state is intentionally providing flexibility in CHIR composition and requirements, to better allow each region to most effectively meet a community’s unique needs. Despite this

diversity, the state is developing standardized metrics of CHIR success, to be developed in consultation with each CHIR.

Overall, interviewees were nearly universally optimistic about the potential of CHIRs to begin to transform health care in the state, and representatives from varied groups expressed excitement about the potential to link medical services with organizations that address the social determinants of health.

F.5 Overall Michigan Summary

The Michigan SIM Initiative builds on the state's *Blueprint for Health*,⁵² which is focused on the Triple Aim.⁵³ The state plans to achieve these goals through three central strategies: (1) building on existing PCMHs and facilitating PCMH transformation for those not yet certified; (2) promoting payment reform and value-based purchasing through ASCs; and (3) supporting an emphasis on population health through CHIRs, by acknowledging the social determinants of health and improving the linkage between the medical and nonmedical services that together help determine overall health. These strategies will be supported through payment models, health IT, and systematic performance measurement and reporting. The SIM Initiative is focused on Medicaid enrollees, with an initial focus on those with high ER utilization. Individuals with multiple chronic conditions and “healthy mothers and babies” are also target populations, as the program matures.

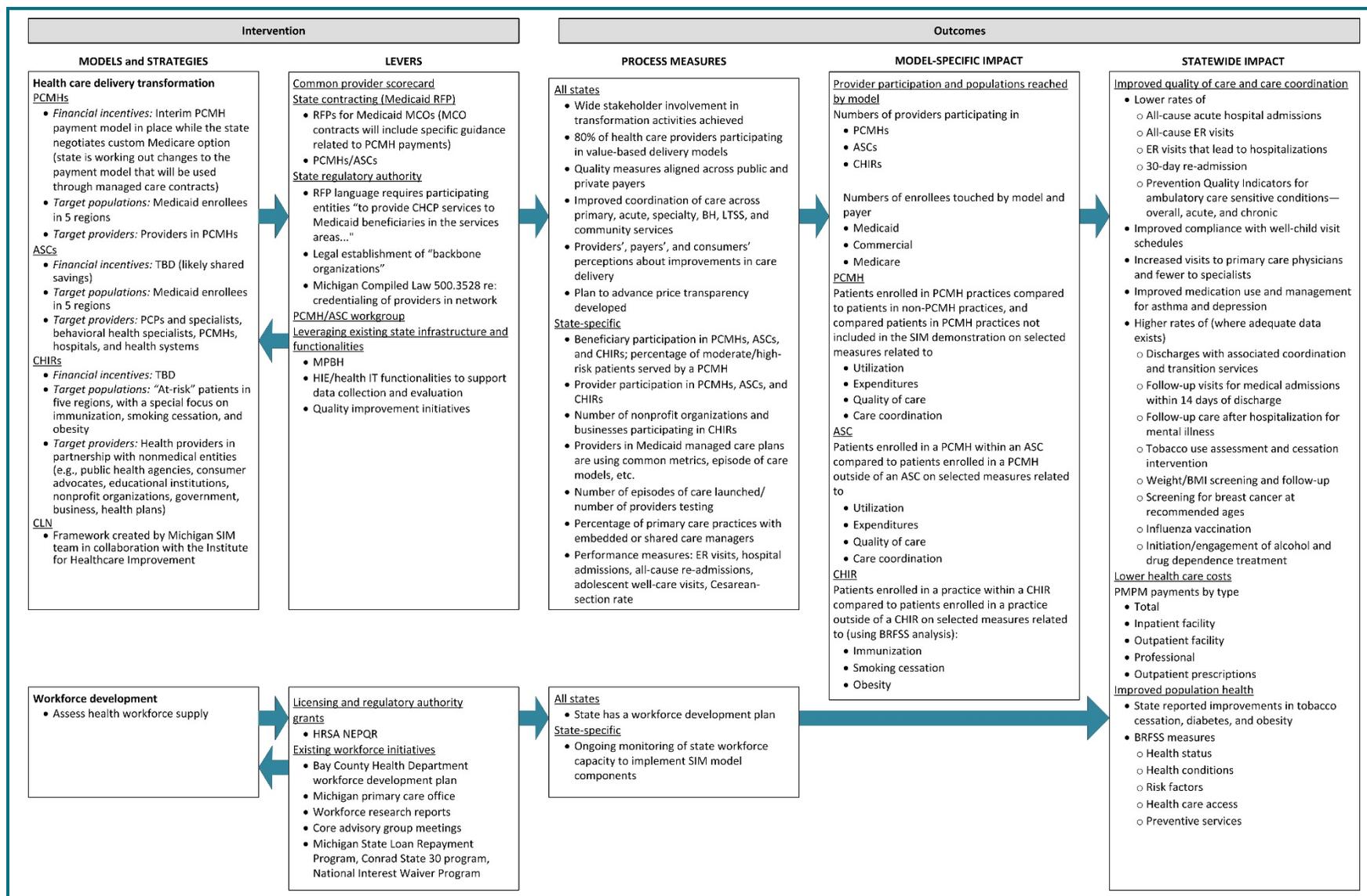
The SIM Initiative has evolved since the planning stages in several critical ways. Although the original plan was to be implemented statewide, the state has shifted focus to five pilot regions chosen for diversity on many factors, including their “readiness” to support SIM activities. The payment model for ASCs is still being developed and varies in some ways from what was described in the state's Model Design plan. At this early point in implementation, the SIM model is not operational, but the state planned to have officially kicked off the major SIM activities in each of the five participating regions by late 2016.

⁵² State of Michigan. (2014, January 24). *Reinventing Michigan's health care system: Blueprint for health innovation*. Retrieved September 7, 2016, from http://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_64491_76091---,00.html

⁵³ Berwick, D. M., Nolan, T. W., & Whittington, J. (2008). The triple aim: Care, health, and cost. *Health Affairs*, 27(3), 759–769. doi: 10.1377/hlthaff.27.3.759

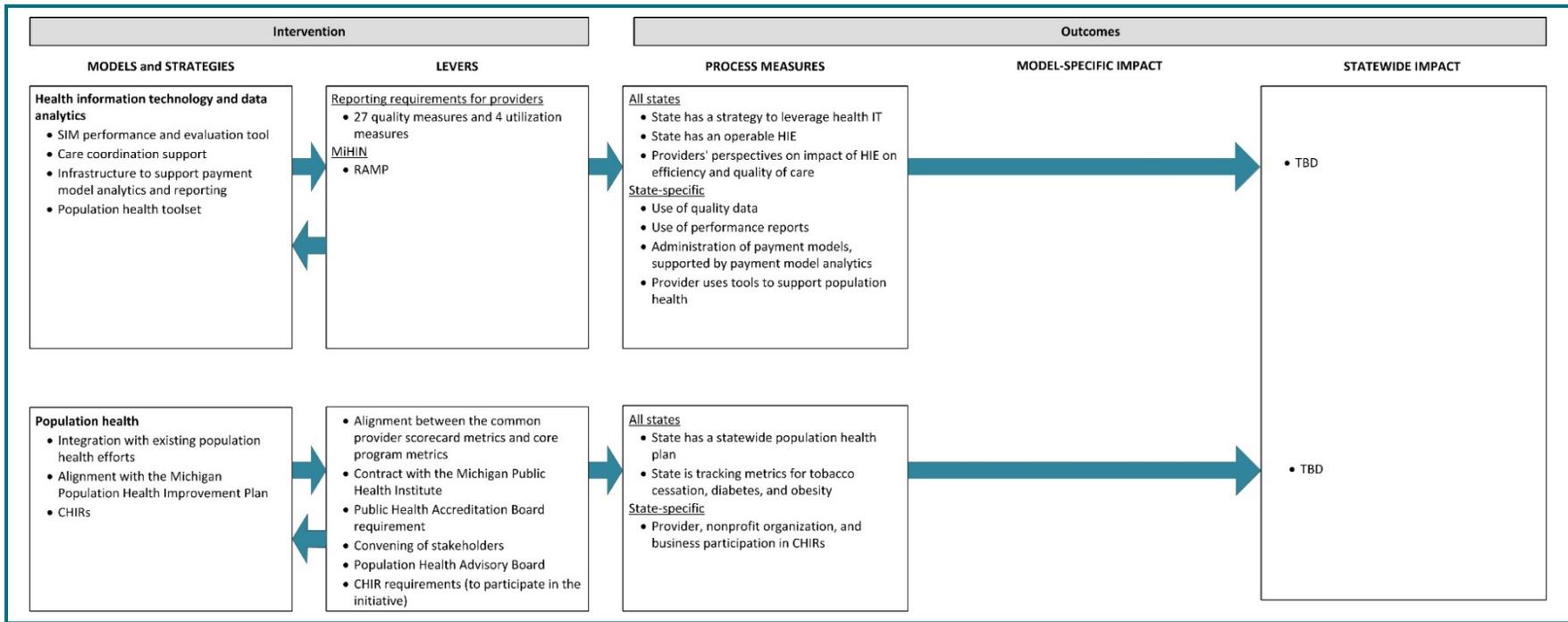
Figure F-1. Logic model for Michigan’s State Innovation Model activities

F-16



(continued)

Figure F-1. Logic model for Michigan’s State Innovation Model activities (continued)



ASC = accountable system of care; BH = behavioral health; BMI = body mass index; CHCP = Comprehensive Health Care Program (Michigan); CHIR = Community Health Innovation Region; CLN = Collaborative Learning Network; ER = emergency room; health IT = health information technology; HIE = health information exchange; HRSA = Health Resources and Services Administration; LTSS = long-term services and supports; MCO = managed care organization; MiHIN = Michigan Health Information Network Shared Services; MPHB = Michigan Pathways to Better Health; NEPQR = Nurse Education, Practice, Quality, and Retention; PCMH = patient-centered medical home; PCP = primary care provider; PMPM = per member per month; RAMP = Relationship and Affiliations Management Platform; RFP = request for proposal; SIM = State Innovation Model; TBD = to be determined.

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Appendix G: New York Site Visit Report

For the 2016 site visit, the RTI team conducted 14 in-person interviews in Albany from May 16 through May 18, and 7 phone interviews with individuals based in other parts of the state, for a total of 21 interviews. The team interviewed New York SIM staff as well as external stakeholders, including representatives from private payers, consumer advocate organizations, and provider organizations. The team also conducted four focus groups during the site visit—two with primary care clinicians in small practices and two with consumers insured through the state’s employee health plan—to learn about their experiences with the current health care system in the state.

This appendix provides an overview of the New York SIM Initiative; describes the current health care context in which the SIM Initiative is being implemented; summarizes early implementation successes, challenges, and lessons learned; and discusses key findings from the site visit interviews and focus groups, organized by major topic area. This appendix includes findings based on qualitative data collected through June 30, 2016. Further details on the analytic approach are available in *Appendix L*. Information on the site visit interviewees for the state is in *Table L-1*, and information on the provider and consumer focus group participants for the state is in *Tables L-4* and *L-5*, respectively.

G.1 Overview of New York’s State Innovation Model

The central component of the New York SIM Initiative is the Advanced Primary Care (APC) model, a New York–specific version of the patient-centered medical home (PCMH) model. New York’s vision is for private payers to make new payments to primary care practices that adopt the APC model, and for state contractors to provide technical assistance (TA) to help practices meet the various APC milestones.

After spending the first year refining the APC model, a main focus of New York’s second year is to contract with regional organizations across the state to (1) provide TA to help primary care practices adopt and implement the APC model, and (2) formally recognize practices when they successfully meet state APC criteria (see *Delivery systems and payment reforms, Section G.3.4*). New York is simultaneously working to secure agreement from private payers to make new payments to practices that sign up to participate in the APC model. One strategy New York is using to encourage payers to participate is providing modest financial incentives through the state’s annual premium rate review process. Specifically, with approval from the Governor’s Office, New York is offering an adjustment to payers’ Medical Loss Ratio (MLR) for 2017 rates, to help offset new investments they may make in alignment with the APC model. In addition, New York SIM staff are advocating for value-based insurance design (VBID) changes to state employee health plans, and possibly new payments for APC practices.

The state also plans to provide APC practices with a Scorecard summarizing their performance on a common set of quality measures across multiple payers. Ultimately, the state hopes to populate this Scorecard using data from a forthcoming All-Payer Database (APD) and the state's improved health information exchange (HIE), the Statewide Health Information Network for New York (SHIN-NY). But for the next year, at least plans are for the Scorecard to be populated using claims data voluntarily reported by payers. To further support the APC model, New York's SIM Initiative includes several health care workforce efforts aimed at (1) developing more reliable data on the numbers and types of health care workers practicing in the state; (2) attracting more workers to primary care careers, including in underserved areas; (3) increasing care coordination capacity; (4) clarifying care coordinator job duties; and (5) assuring the availability of care coordination training and certification, as needed.

To improve population health, New York is considering awarding SIM funds to communities to bring together stakeholders to develop a portfolio of interventions that address a common health improvement goal. Finally, to manage SIM activities, the state established a small office within the New York State Department of Health (NYSDOH) called the Innovation Center. The center has contracted with an array of vendors and is obtaining feedback from internal and external stakeholders through several work groups.

New York has identified several state-specific goals for its SIM work. For example, within 5 years, the state is aiming for 80 percent of primary care practices to be practicing consistent with the APC model of care, and for 75 percent of primary care practices to be in shared-risk payment arrangements with payers.

G.2 Logic Model

Figure G-3, located at the end of this appendix, is a logic model of New York's SIM Initiative, depicting the hypothesized relationship between specific elements of the state's SIM Initiative and changes in outcomes. Column 1 describes the models and strategies New York is pursuing with its SIM funds. Column 2 describes specific policy levers the state is contemplating using to implement these models and strategies.

The remaining columns in the logic model identify the expected impacts of the SIM activities. Specifically, Column 3 primarily identifies process measures CMS and the state hope to influence through New York's SIM Initiative (e.g., getting 80 percent of health care providers to participate in value-based delivery models, and 90 percent of primary care providers [PCPs] to participate in the APC model). Column 4 identifies model-specific outputs expected to be achieved through the state's core SIM activity: deployment of the APC model among primary care practices, supported through SIM-funded TA and new payer-funded payments. Column 5 identifies statewide patient outcome measures CMS hopes to influence in all SIM Round 2

Model Test states (e.g., lower rates of all-cause emergency room visits, lower health care costs per member per month [PMPM]).

G.3 Implementation Activities

G.3.1 Context of health care system

State and nonstate stakeholders alike variously characterized the New York State health care system as vast, diverse, complicated, competitive, and one through which a lot of money flows. It was also described as a system that possesses multiple strengths. Chief among them is the solid health care infrastructure that exists across the state, with centers of excellence in several areas. Supporting this infrastructure, some stakeholders remarked that the state has committed health care leadership to the SIM Initiative across the board, from the Governor’s Office, to the Medicaid agency, to private payers. A long-standing tradition of supporting comprehensive public health care programs was identified as another pillar of the New York health care system. As an example of this, one interviewee highlighted the state’s robust Medicaid and Children’s Health Insurance Program programs—which covered a relatively comprehensive range of individuals well before the Affordable Care Act (ACA).

New York has a history of pursuing care delivery and payment transformation initiatives. State officials felt the background knowledge they had developed regarding the PCMH care delivery model and associated payment models, in particular, has helped them develop the APC model. Among other programs, stakeholders cited the multi-payer Adirondack Medical Home Demonstration (which eventually included Medicare as part of CMS’s Multi-Payer Advanced Primary Care Practice Demonstration) and the multi-payer initiative in the Capital District-Hudson Valley Region, which also included Medicare (through CMS’s Comprehensive Primary Care initiative[CPCi]), as particularly influential. New York also has promoted development of the PCMH model through other initiatives, such as through PMPM payments available from Medicaid to practices that become formally recognized as a PCMH by the National Committee for Quality Assurance (NCQA).⁵⁴ In addition, several private payers have sponsored initiatives aimed at transforming primary care.

Stakeholders also observed that New York has a well-developed, academic medical community which, among other things, trains a sizable share (estimated by one interviewee at 20 percent) of the nation’s physicians. Competition among the many commercial payers participating in New York’s health care market was mentioned as another asset. More than 10 payers participate in the commercial market alone, including large, national payers and smaller, regional payers.

⁵⁴ New York State Department of Health. (2013, April). *The Patient-Centered Medical Home Initiative in New York State Medicaid: Report to the legislature*. Retrieved September 14, 2016, from https://www.health.ny.gov/health_care/medicaid/redesign/docs/pcmh_initiative.pdf.

While highlighting its strengths, interviewees readily acknowledged that the New York health care system also has downsides. Indeed, at least a couple of stakeholders observed that some of the system's biggest strengths are also its biggest weaknesses. For example, stakeholders felt that having a lot of payers in the market makes for an innovative, competitive market, but it also makes it difficult to implement multi-payer payment initiatives like the APC model at the center of the SIM Initiative, since numerous payers must be brought on board. Some also noted that having a lot of payment and delivery system reform efforts under way, as well as many payers and provider organizations, makes it challenging for state officials to get different stakeholders to agree on a consistent care delivery and payment model, since "everyone likes to do things in their own way."

In a similar vein, while emphasizing that New York has among the nation's finest medical institutions, several interviewees felt the state has a "very inpatient- and hospital-focused delivery system." Hospitals were described as possessing significant financial resources and political clout, in part because hospitals are major employers in the state. Overlaying this, hospital employees are represented by powerful labor unions. Combined, these features of New York's health care landscape were viewed as being particularly challenging to efforts to move the state's health care system to one that focuses more on ambulatory and community-based care, such as the SIM Initiative.

State officials, payers, and market observers viewed New York's spending on health care as high compared to other states, particularly in the New York City area; these observers described spending in the upstate area as more reasonable.⁵⁵ At the same time, many stakeholders commented that the quality of health care in the state is not commensurate with how much is spent. Highlighting New York's low ranking in the Leapfrog Group's annual Hospital Safety Grade,⁵⁶ which is based on hospitals' performance on 30 patient safety measures, one interviewee described health care quality in the state as being in the "middle of the road to low."

Another weakness of New York's health care system noted by several stakeholders is shortages of physicians and health care workers, particularly in rural areas of the state but also in low-income areas downstate, including in New York City. While not necessarily characterized as a weakness, a unique feature of New York's physician market, according to interviewees, is that many primary care doctors still practice in offices led by only one or two providers—a pattern found both upstate and downstate. Though state officials described this statistic as changing, they estimated that between 35 and 40 percent of New York primary care doctors were working in such practices. Stakeholders explained that the sizable presence of these small practices has been a longstanding tradition among New York primary care doctors, who were described as valuing

⁵⁵ The Henry J. Kaiser Family Foundation. (2017). *Medicare spending per enrollee, by state [timeframe: 2014]*. Retrieved July 17, 2017, from <http://kff.org/medicare/state-indicator/per-enrollee-spending-by-residence/>.

⁵⁶ Hospital Safety Score. (2016, April). *How safe is your hospital? State rankings*. Retrieved September 14, 2016, from <http://www.hospitalssafetyscore.org/your-hospitals-safety-score/state-rankings>

their independence and reluctant to change the way they deliver care—in part due to being financially less able to make investments in new staff or technologies. As a result, several stakeholders acknowledged that it will be a challenge for these doctors to implement the APC model.

Many of these interviewee views about New York’s primary care physicians were echoed in the two focus groups we conducted with non-PCMH primary care clinicians, who tended to work in small practices led by one or two providers. These clinicians generally felt frustrated and overwhelmed and had many complaints about the current burdens they faced. Highlights from the clinician focus groups include the following views:

- Insurers subjected physicians to increasing amounts of paperwork and “hassles” when they tried to obtain prior authorizations and approvals for services on behalf of patients.
- Adopting electronic health records (EHRs) had been costly and difficult, and meeting the criteria to qualify for “meaningful use” EHR incentive payments had been frustrating.
- It cost a lot to connect to a regional or statewide HIE, and clinicians were frustrated that different “EHRs were not interoperable with one another.
- It took time and effort to piece together what was going on with their patients, since patients were usually not required to get referrals from their primary care provider (PCP) to see specialists. As a result, several clinicians commented that they did not always know about care their patients were receiving from other providers.
- Pay-for-reporting efforts such as the CMS Physician Quality Reporting System were viewed as too much work for small practices, and the quality measures these and other programs used did not take into account that patients ultimately make their own decisions about what services to receive.

Several of the clinicians in the focus groups reported that they had not adopted the PCMH model of primary care—either because they had not heard of it before, or because they viewed it as too expensive to hire care coordinators and too time-consuming to learn about the model. A few actually pleaded for no more new programs to be introduced—viewing them as costing providers time and money and taking time away from patient care.

Consumers shared their own perspectives on primary care in the two focus groups with consumers covered by the state’s employee health plan. Most of them had seen a health care provider multiple times in the past year but were healthy enough that they would not typically be considered a candidate for enhanced care management or coordination through a PCMH. All the focus group consumers described their primary care practices as at least mid-sized.

Consumer focus group participants generally viewed their PCPs positively. Several said their PCP explains things in a way they can understand, does not rush them during visits, listens to them, responds to questions between appointments, and would recognize them on the street. A few mentioned being referred to nutrition classes or diabetes management educators. Participants, however, did air some complaints, such as in-office wait times are too long, or their PCP does not take into account their preferences about treatment options.

Stakeholders expressed mixed views about whether patients' PCPs and specialists communicated with each other, with some reporting having to be personally involved to make sure different providers got records from one another. In one focus group, the idea of a care manager emerged organically from the conversation, after one participant mentioned wanting an "expert buddy" to call, which was also described as a "medical concierge." Many participants in this focus group agreed they also would like to have access to such a person, whom they could call when they have questions about health care and who would periodically reach out to check in on them.

A final important piece of New York's health care landscape that pertains to its SIM Initiative is that the state is simultaneously launching other efforts to transform primary care delivery and payment. A major one is the Medicaid Delivery System Reform Incentive Payment (DSRIP) Program, which is offering TA to primary care practices serving safety-net populations to help them attain PCMH or APC designation.⁵⁷ New York also is offering learning collaboratives to primary care and specialty practices (with a focus on larger practices) as part of the CMS Transforming Clinical Practice Initiative (TCPI). In addition, the APC model will provide TA to PCPs, but with a focus on smaller practices. Other key differentiating factors of APC TA are that it will focus on educating practices about the APC model of primary care and the various milestones associated with each of the three "gates" in this model. APC TA vendors will be responsible for certifying APC practices as having met the criteria for different APC Gates. Recognizing the overlap between the SIM Initiative's APC model, DSRIP, and TCPI, the state already has dedicated resources to help clarify for stakeholders participating in the SIM planning process the differences among the various initiatives, such as through meetings that include presentations of crosswalks comparing different programs presented.

While acknowledging that all these transformation efforts are generally trying to reach the same goal of changing the way primary care is delivered and paid for, several stakeholders expressed frustration at the lack of alignment among them—particularly when it came to the different sets of quality measures each program requires providers to report. A few interviewees pointed out that shortly after CMS released its Core Quality Measures (CQM), meant to promote

⁵⁷ New York State Department of Health. (2016, August). *Delivery System Reform Incentive Payment (DSRIP) program*. Retrieved September 14, 2016, from http://www.health.ny.gov/health_care/medicaid/redesign/dsrp/.

multi-payer alignment,⁵⁸ CMS launched the Comprehensive Primary Care Plus (CPC+) initiative using measures that did not align with the CQM set.⁵⁹ Many stakeholders expressed considerable concern that so many programs coming out at the same time (at both the state and federal levels) may cause “transformation fatigue.” According to several interviewees, many providers in the state had been involved in earlier efforts that required them to take on additional work beyond their day-to-day duties (e.g., taking time to learn how to use EHR systems or modifying practice workflows to accommodate such systems). Because of these previous efforts, providers may choose to not participate in the APC model. A gap one interviewee commented on was the lack of any single entity available to explain all the various payment and delivery system reform initiatives to providers and help them identify which one would be most financially advantageous for them to join—given the number of their patients insured by particular payers, the different initiatives each payer was offering, and the demographics and chronic disease burden of their patient panel.

Apart from delivery and payment initiatives, another important SIM activity is the state’s Prevention Agenda 2013-2018.⁶⁰ As New York has worked on the development phase of the SIM Initiative, it has sought to align population health metrics and milestones embodied in Prevention Agenda activities with clinical care delivered by APC practices.

Interviewees noted that several features of New York’s health care system discussed above could affect SIM implementation. For example, many interviewees commented on the considerable diversity of New York’s primary care landscape, which ranges “from small, rural practices in frontier areas to large, complex, semi-integrated systems, and everything in between.” A one-size-fits-all approach will thus not work in New York, which will be an implementation challenge. Another is the large number of payers that participate in New York’s health care market. State officials commented that, while payers generally have been very engaged in the SIM Initiative, having to deal with so many payers has slowed implementation and is likely to continue to do so as implementation progresses. The power of New York hospitals and the strong, vested interests of hospital workers’ unions wanting to maintain employees’ benefits and salaries, were also acknowledged as potentially affecting the state’s ability to make a shift from a delivery system focused on acute care to one focused on

⁵⁸ Centers for Medicare & Medicaid Services. (2016, February). *Core measures: Overview*. Retrieved September 14, 2016, from <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Core-Measures.html>.

⁵⁹ Center for Medicare & Medicaid Innovation. (2016, August 1). *Comprehensive Primary Care Plus (CPC+): Practice frequently asked questions*. Retrieved September 14, 2016, from <https://innovation.cms.gov/Files/x/cpcplus-faqs.pdf>.

⁶⁰ New York State Department of Health (2016, August). *Prevention agenda 2013–2018: New York State’s Health Improvement Plan*. Retrieved September 14, 2016, from https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/.

ambulatory care. An additional and important potential hurdle New York SIM staff may face is convincing physicians working in small, primary care practices to implement the APC model.

Overlaying these issues, is another potential implementation issue—the 2015 demise of Health Republic Insurance of New York, a consumer operated and oriented plan established to compete in New York’s health insurance (Affordable Care Act) marketplace. New York officials viewed the failure of Health Republic as creating a large and unanticipated distraction for the state in promoting the SIM Initiative. In addition, the failure raised questions about the credibility of the health plan rate review process annually conducted by the New York State Department of Financial Services (DFS). The rate review process is an important policy lever New York hoped to use to promote plan participation in the APC model.

G.3.2 Governance and program administration

As noted earlier, New York’s SIM Initiative is directed and staffed out of the NYSDOH’s new Innovation Center. The state Innovation Center’s SIM work is guided by the Health Innovation Council, which meets a few times per year and is composed of state officials and external stakeholders. One state official reported involvement of the Governor’s office in the SIM Initiative as being “as high a level as you can get without having the Governor on the [Health Innovation] Council, himself.” The commissioner of health and the secretary for health, a political appointee, also were described as being closely involved in the New York SIM Initiative. Several state officials reported that weekly meetings take place between SIM-involved officials at NYSDOH and representatives from the Governor’s office.

Most individuals working on the planning for and implementation of the New York SIM Initiative are housed in several NYSDOH offices, divisions, and advisory boards—including, but not limited to, the Office of Public Health, Office of Quality and Patient Safety, Office of Health Insurance Programs, Office of Primary Care and Health Systems Management, Office of Rural Health, and State Council on Graduate Medical Education. Several state agencies outside NYSDOH are also involved—including DFS, which has regulatory authority over an estimated 50 percent of the state’s commercially insured market; the Department of Civil Service (DCS), which manages the state employee health plan; Public Health and Health Planning Council; and the Office of Mental Health.

To solicit input from and achieve consensus among numerous stakeholder groups, both within and outside state government, the state Innovation Center has convened several work groups: an Integrated Care Workgroup, focusing on the APC effort; a joint SIM-DSRIP Workforce Workgroup; and a Measurement, Evaluation, and Health Information Technology (health IT) Workgroup. The state originally planned for a fifth work group focused on population health, but, in an effort to embed population health in all SIM activities, the state ultimately opted to include population health–focused stakeholders on the remaining four work groups. In

addition, a few state staff members are working on identifying opportunities to improve New Yorkers' access to care. The Integrated Care Workgroup meets on a monthly basis, with the remaining groups convening less frequently. Work group members are given the opportunity to attend meetings in person or by phone, and meeting locations (at least for the Integrated Care Workgroup) often alternate between an upstate and downstate venue, to allow for geographic diversity of in-person attendees. The NYSDOH website posts slides from the meetings.⁶¹

External stakeholders on the work groups include representatives from health plans, employers, hospitals, medical societies, consumer representatives, and behavioral health providers. Since many of the same individuals were likely to be invited to participate in both DSRIP and SIM work groups on the workforce topic (and there was the worry of “work group fatigue” as one state official put it), the state decided to create a combined workforce work group spanning both the SIM Initiative, which is focused on primary care practices with large shares of commercial patients, and DSRIP, which focuses on practices with large shares of Medicaid patients.

NYSDOH staff use the work groups to solicit stakeholder input on outlines, drafts, and templates, but ultimate decision-making authority remains with state officials. According to one interviewee, NYSDOH has done a fine job of “[striking] the right balance between providing guidance and decision-support and allowing for the leadership and direction to come from the talented volunteers that they have asked to do this work.” Another interviewee described NYSDOH as being “responsive to work group concerns.” Perhaps the best example of this is the state’s response to payers’ concerns about a potential conflict of interest arising from the fact that regional contractors hired to provide APC TA would also be the entities that determine which of three APC Gates a practice qualifies to be in (with higher gates triggering higher payments from payers). To ensure each primary care practice actually meets the APC standards its regional contractor claims it has met, the NYSDOH Innovation Center has decided to use SIM funding to contract with an independent entity to audit regional APC TA vendors’ assessments of practices’ APC Gate levels. Having an independent auditor was not originally envisioned in New York’s SIM application, but was added in response to payers’ concerns.

Apart from the work groups, the state has contracted with a number of outside contractors as part of its SIM work, including the Northeast Business Group on Health (NEBGH) and McKinsey & Company. The former has convened an advisory group for commercial health insurers and an advisory group for large, self-insured employers, to try to generate interest in making new payments to APC practices. The latter was brought on to facilitate work group

⁶¹ New York State Department of Health. (2016, August). *The New York State Health Innovation Plan: Workgroups and Innovation Council*. Retrieved September 14, 2016, from https://www.health.ny.gov/technology/innovation_plan_initiative/workgroups.htm.

meetings and to act in an advisory role, particularly with regard to facilitating APC implementation.

Regarding the sufficiency of monetary resources tied to the New York SIM Initiative, interviewee opinions were mixed. State officials generally felt that SIM funds would cover the cost of planned activities. However, a few external stakeholders expressed either the worry that too much SIM funding is being spent on consultants or the feeling that funding should be provided directly to practices, rather than to TA entities that will work with practices.

G.3.3 Stakeholder participation

Although consumer advocates interviewed felt there was under-representation of consumers on the Integrated Care Workgroup, numerous state officials and external stakeholders described broad and meaningful stakeholder involvement. One official thought the frequency and intensity of multi-stakeholder participation taking place is a “new” experience for the state. Asked to explain the success the state has had in convening stakeholders, one official explained, “[t]here’s so much momentum going towards this value-based payment thing—between CMS and Medicaid and commercial. The writing is on the wall. The train’s leaving the station, and for these groups, it’s a great opportunity for them to voice their concerns.”

When asked for their opinions regarding which stakeholders are most important to the SIM Initiative, multiple informants pointed to the organizations representing primary care practices. Another interviewee said payers and consumers are equally important to include in the SIM work groups. While the state does not claim to have achieved a consensus among all stakeholder groups on all aspects of the SIM Initiative, as one state official said, “there is general agreement that what we’re trying to do makes sense. I don’t think anyone sees any other solution like this coming down the pipe to address the increases in cost within the health care system. Everyone recognizes that there is a need.”

An important group that one state official felt is missing from the stakeholder engagement process is physicians practicing in small primary care practices, who are usually too busy to find time to advise SIM-like initiatives: “It’s like herding cats trying to herd individual physician practices that aren’t necessarily at the table. And you can’t get them at that table; they don’t have time.” This interviewee felt that the process of developing the APC care delivery model would have been enhanced if there had been more involvement from PCPs who work in small practices, since these types of physicians are the target audience of the new care delivery model.

Although most stakeholders that the RTI team interviewed described state receptiveness to input and a demonstrated flexibility to amend programmatic structures to assuage stakeholder concerns, consumer representatives involved in the SIM Initiative complained of a “higher than normal” level of disregard for their input, especially as it relates to engaging consumers on the

APC model design. Consumer representatives reported submitting several sets of comments, few of which were adopted into the APC model, including:

- that NYSDOH sponsor regional convenings with health consumers and community-based organizations, as well as focus groups with consumers, to solicit each group’s desires and needs related to APC—much in the same way as NYSDOH had hired the NEBGH to convene regional meetings with commercial health insurers and employers;
- that community-based services (e.g., exercise programs, chronic disease self-management support programs) be incorporated into APC standards; and
- that practices be required to survey patients on a quarterly or monthly basis.

Consumer representatives did highlight one major concession made by the state: inclusion of a requirement that a “care plan” be developed for every patient in a practice. (Originally, such a requirement had been included, but was limited to complex patients.)

G.3.4 Delivery systems and payment reforms

The component of the New York SIM Initiative that was clearly the state’s highest priority and commands the largest share of SIM resources was the APC model for primary care practices. Upon receiving its Model Test award, New York quickly established its Integrated Care Workgroup and spent the bulk of the first year of the SIM award fleshing out the details of the APC care delivery model—which, as noted, will have three Gates for practices to pass through as they become more advanced.

The main difference between the APC care delivery model originally envisioned and the model ultimately developed is that more preparatory stages have been added, with intensive care management not occurring until Gate 3, the most advanced gate. (In contrast, the thinking in the state’s SIM Model Test application was that this sort of activity would begin in the *second* stage of a practice’s APC evolution, and that this second stage might be some practices’ “final destination.”) As shown in **Figure G-1**, the state currently expects specified activities to occur at each of its three APC gates.

In mid-2016, the focus of state staff’s efforts has shifted to getting formal commitments from the state’s many private payers to offer new payments to practices that adopt the APC model. Individuals involved in the state’s SIM Initiative had different understandings of if, or how many, payers will participate in the APC model. State staff tended to sound confident that payers will voluntarily join this initiative, but some payer and provider stakeholders were less certain. One state official claimed that a third of New York’s commercial health insurers are “willing, ready, and doing some version” of APC; a third “will need convincing and coaxing”; and a third “are like, ‘not today, not tomorrow.’” As noted earlier, the state also is trying to convince large, self-insured employers to make new payments to APC practices.

Figure G-1. Advanced Primary Care milestones for practices to achieve at Gate 1, Gate 2, and Gate 3

	Commitment Gate 1	Readiness for care coordination Gate 2	Demonstrated APC Capabilities Gate 3
	<i>What a practice achieves on its own, before any TA or multi-payer financial support</i>	<i>What a practice achieves after 1 year of TA and multi-payer financial support, but no care coordination support yet</i> Prior milestones, plus ...	<i>What a practice achieves after 2 years of TA, 1 year of multi-payer financial support, and 1 year of multi-payer-funded care coordination</i> Prior milestones, plus ...
Participation	i. APC participation agreement ii. Early change plan based APC questionnaire iii. Designated change agent / practice leaders iv. Participation in TA Entity APC orientation v. Commitment to achieve gate 2 milestones in 1 year	i. Participation in TA Entity activities and learning (if electing support)	
Patient-centered care	i. Process for Advanced Directive discussions with all patients	i. Advanced Directive discussions with all patients >65 ii. Plan for patient engagement and integration into workflows within one year	i. Advanced Directives shared across medical neighborhood, where feasible ii. Implementation of patient engagement integrated into workflows including QI plan (grounded in evidence base developed in Gate 2, where applicable)
Population health			i. Participate in local and county health collaborative Prevention Agenda activities ii. Annual identification and reach-out to patients due for preventative or chronic care management iii. Process to refer to structured health education programs
Care Management/ Coord.	i. Commitment to developing care plans in concert with patient preferences and goals ii. Behavioral health: self-assessment for BH integration and concrete plan for achieving Gate 2 BH milestones within 1 year	i. Identify and panel highest-risk patients for CM/CC ii. Process in place for Care Plan development iii. Plan to deliver CM / CC to highest-risk patients within one year iv. Behavioral health: Evidence-based process for screening, treatment where appropriate ¹ , and referral	i. Integrate high-risk patient data from other sources (including payers) ii. Care plans developed in concert with patient preferences and goals iii. CM delivered to highest-risk patients iv. Referral tracking system in place v. Care compacts or collaborative agreements for timely consultations with medical specialists and institutions vi. Post-discharge follow-up process vii. Behavioral health: Coordinated care management for behavioral health
Access to care	i. 24/7 access to a provider	i. Same-day appointments ii. Culturally and linguistically appropriate services	i. At least 1 session weekly during non-traditional hours
HIT	i. Plan for achieving Gate 2 milestones within one year	i. Tools for quality measurement encompassing all core measures ii. Certified technology for information exchange available in practice for iii. Attestation to connect to HIE in 1 year	i. 24/7 remote access to Health IT ii. Secure electronic provider-patient messaging iii. Enhanced Quality Improvement including CDS iv. Certified Health IT for quality improvement, information exchange v. Connection to local HIE QE vi. Clinical Decision Support
Payment model	i. Commitment to value-based contracts with APC-participating payers representing 60% of panel within 1 year	i. Minimum FFS with P4P ² contracts with APC-participating payers representing 60% of panel	i. Minimum FFS + gainsharing ³ contracts with APC-participating payers representing 60% of panel

Source: Gesten and Friedrich (2016).⁶²

APC = Advanced Primary Care; BH = behavioral health; CC = care coordination; CDS = clinical decision support; CM = care management; FFS = fee-for-service; HIT = health information technology; health IT = health information technology; HIE = health information exchange; P4P = pay-for-performance; QE = qualified entity; QI = quality improvement; TA = technical assistance.

¹ Uncomplicated, non-psychotic depression

² Equivalent to Category 2 in the October 2015 HCP LAN Alternative Payment Model (APM) Framework

³ Equivalent to Category 3 in the APM Framework

⁶² Gesten, F., & Friedrich, M. (2016, April 4). APC webinar. New York State Department of Health. Retrieved from https://www.health.ny.gov/technology/innovation_plan_initiative/docs/2016-04-04_apc_webinar.pdf.

Since many private payers tend to operate in some regions of the state and not others, and because of the great diversity of the health care market that exists across the state, New York's plan for implementing the APC model is to identify regions with a sufficient number of willing payers, and to award contracts first to organizations to serve as APC TA vendors in those regions. This regional APC TA for practices will command nearly two-thirds of the state's total SIM award, or about \$62 million. (The state was beginning to review proposals from organizations that had applied to serve as these TA vendors at the time of the May 2016 site visit. The state hoped to award contracts in summer 2016, to enable TA vendors in selected regions to begin working with practices in September 2016. Thirteen applicants, covering all regions of the state, had submitted 19 applications.)

One external stakeholder doubted that payers would want to sign up to offer new APC payments, until the state identified which regions had the largest number of willing practices. Payers likely have a finite amount of money they are willing to spend on incentive payments, and, therefore, may want to offer them only in one region initially, according to this interviewee's reasoning. Another stakeholder doubted that providers will want to commit to participating, until they have a clearer understanding of the generosity of the APC payments and the number of patients for whom they will likely receive these payments, which will be determined based on the number of payers participating in a particular region. Perhaps the most positive, concrete signal the state received was from an Albany-area health plan that submitted an application to serve as one of the regional APC TA vendors a few weeks before the May 2016 site visit. State officials took this to mean that the plan is likely to offer at least some contracted practices in its provider network new payments for adopting the APC model.

To help encourage payers to voluntarily participate in the APC model, a few weeks before payers were required to submit their applications for premium increases for the 2017 plan year, DFS announced that it will allow insurers to have a higher MLR if they are making practice transformation and care coordination payments to practices. For example, if a payer projects that the value of practice transformation and care coordination payments will equal 0.4 percent of the value of its expected total premiums, that payer will be permitted to submit an MLR 0.4 percent higher than DFS would otherwise have allowed.

According to one interviewee, the last-minute nature of this announcement upset payers, since it left them with insufficient time to revise their 2017 rate applications. As a practical matter, it also seemed to this interviewee that DFS's offer will "have no real effect." Most New York plans already exceeded the state's minimum MLR of 82 percent, and thus were not looking for new clinical services or quality improvement activities to help them reach the minimum. It was also unclear to this interviewee whether the federal government, which has its own requirements about plans' MLRs, will accept the state's determination that new APC payments

could count in the numerator of a plan’s MLR—leading this person to describe DFS’s offer as “too little, too late.”

At the time of the RTI team’s 2016 site visit, the state was working on identifying an additional carrot to offer payers, and was considering offering payers a premium credit. For example, if a payer expects that the cost of new APC payments to practices will require raising premiums by 1 percent, the payer can request a premium rate increase 1 percent higher than they would otherwise request; the state will automatically accept the portion of the payer’s request that will cover new APC payments. Although this policy had not yet been adopted, a payer that the RTI team interviewed felt that such a premium credit would be more appealing than the current offer to allow higher MLRs—in part because most payers already had a higher MLR than the state required. That said, this payer felt it was unfair to only offer the credit to payers who begin making new payments to APC practices in 2017, and not to payers already making APC-like payments to practices: “So *I’ve* been spending for the last 2 years and been a good actor, and I get no credit? *You* haven’t done a thing, and you’re going to get a benefit?”

In some cases, interviewees said they felt payers had already moved past the APC or PCMH model by embracing accountable care organization–style contracts with large shares of their providers—suggesting that such payers would be “back-sliding” if they adopted the APC model, which was perceived by some as providing weaker provider incentives to improve quality and reduce costs, compared with other models already in operation.

The state does not plan to mandate payer participation in the APC model. In part this may be attributable to the political fallout DFS experienced after it approved Health Republic’s reported low rates and then had to shut it down in 2015 due to financial losses.⁶³ (In DFS’s defense, Health Republic’s demise was in large part due to deep federal cuts to a risk corridor program for consumer operated and oriented plans, which reduced an expected infusion of funds from \$200 million to \$19 million.⁶⁴) At the time of the May 2016 site visit, state staff said that Republican members of the New York State legislature were considering revoking DFS’s powers to review and approve premium increases in response to this “debacle,” as one interviewee put it—although several stakeholders said they thought the Governor, a Democrat, would not sign such a measure, were it to pass. As one state official put it: “The failure of Health Republic created a large obstacle we didn’t anticipate—it put the whole rate review process up to question.” If New York were to lose its ability to review and approve insurers’ annual requests

⁶³ The Associated Press. (2015, September 25). New York State orders Health Republic Co-op to end new business. *The New York Times*. Retrieved September 14, 2016, from http://www.nytimes.com/2015/09/26/nyregion/new-york-state-orders-health-republic-co-op-to-end-new-business.html?_r=0.

⁶⁴ Waldholz, M. (2016, April 17). The short and chaotic life of an Obamacare darling. *Crain’s New York Business*. Retrieved September 14, 2016, from http://www.craigslist.com/article/20160417/HEALTH_CARE/160419890/the-short-and-chaotic-life-of-an-obamacare-darling.

for premium increases, as noted, the state would lose a primary policy lever it had planned to use to incentivize payer participation in the APC model.

State officials noted that, at the time of the site visit in May 2016, no payer had yet signed on to pay practices for implementing the APC model. These officials also said they would have liked to have had firmer commitments from payers by this stage in their SIM Initiative. In hindsight, one official thought they should have “engaged payers and providers more aggressively and more quickly,” including developing a solid business case for payers sooner in the process; and that, if they had done so, “we might be more on track now and maybe more successful.” Another official said they had “probably spent more time on [APC] capabilities of practices and milestones than maybe we needed to—we could have shut that door a little sooner than we did.” Although one payer complimented the state for recently surveying the state’s payers to understand what APC-like payments they were already making, this interviewee also felt the state “really could have done the survey sooner ... they could have done something earlier on to narrow their focus and scope.” This sentiment was echoed by a state official who also felt that, in hindsight, the survey should have been released earlier, “because then you can identify areas of alignment that you have already.”

The survey in question was a voluntary request for information (RFI) that DFS sent to 18 commercial health insurers in early 2016, which asked about the degree to which their existing plans incorporated VBID and support for APC-like initiatives. By mid-April, the state had received responses from 12 payers—representing what the state considered to be a 100 percent response rate among major insurers offering commercial and Medicare Advantage plans. Six payers that offer mostly Medicaid plans did not respond to the RFI. In mid-May, SIM staff summarized their key findings from the RFI as follows:

- All 12 responding insurers reported incentivizing team-based care, and 11 reported providing practice transformation support (e.g., stipends, supplemental PMPM payments), although investments in value-based programs as a percentage of their total spending varied widely. Similarly, the percentage of members covered by such programs ranged from 1 percent to 65 percent in commercial plans and 3 percent to 65 percent in Medicare Advantage plans. These payers also reported various types of in-kind support (e.g., data analytics).
- In answer to a question about payers’ degree of readiness to implement APC in their networks, four payers believed their current programs already met the APC requirements and that they were essentially already making APC-like payments to practices; three reported being ready to support APC in 2017; one reported being ready in 2018; one said it would consider supporting APC but gave no timeline; one needed more information before making a decision; and three payers declined to comment on whether they would commit to financially supporting the APC model. (Some payers gave more than one answer to this question.)

Based on the detailed information collected through this RFI, the next step for state officials was to clarify some payers' responses and try to secure commitments from payers to make new APC payments to practices. The state has suggested to payers that they pay practices in Gate 1 \$1.50-\$3.00 PMPM to support practice transformation efforts, and pay practices in Gate 2 and Gate 3 \$4.00 to \$10.00 PMPM for care coordination services. However, since the state does not plan to mandate participation in the APC model, it is giving participating payers the freedom to structure and decide the amounts of APC fees they pay to participating practices. That said, one state official involved in payer recruitment said the state had a clear preference for some kind of *prospective* payments to practices: "What we don't think is a very productive thing is: in a year and a half or 2 years, maybe—based on some formula that no one can understand—you may get some additional money," since "practices need support now, to put infrastructure in place that, otherwise, fee for service doesn't pay for or doesn't pay adequately for." Ideally, the state expressed the hope that payers will commit to offering some sort of up-front payments to practices that have achieved the criteria to be a Gate 2 practice, and some form of outcome-based payment (e.g., shared savings) for the more advanced practices in Gate 3. The state's recommended payment model for APC practices is shown in *Figure G-2*.

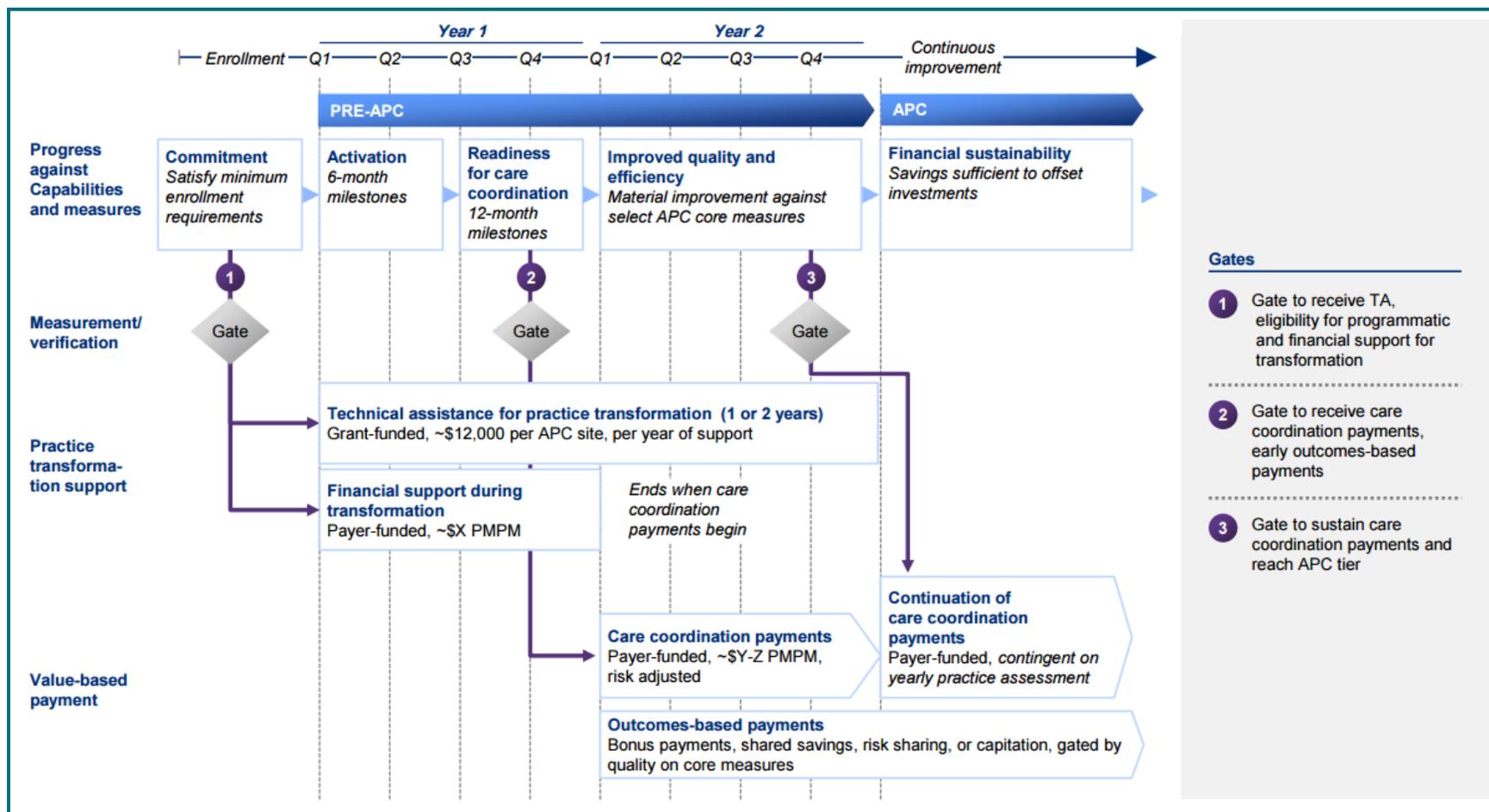
Despite this flexibility, one stakeholder noted that "the commercial payers have been as noncommittal as they can be" and that "it'll be hard to get to the next step of SIM" (i.e., getting regional APC TA vendors to work with practices to adopt the APC model), until payers commit to offering new payments to support transformation work. According to this stakeholder, without commitments from payers, "I don't know how they're going to be able to sell this to providers."

To accompany APC TA provided by regional organizations and new payments from payers, the state also plans to provide participating practices with an APC Scorecard, as noted, summarizing practices' performance on a common set of quality measures agreed to by all participating payers. While this measure set was initially expected by state staff to include 18 measures, the list was amended by state staff to align with CMS's recently released CQM, which resulted in the Scorecard expanding to 28 measures. After an additional set of measures was announced for CMS's new CPC+ program, the state planned to revisit its Scorecard measure set yet again, in an effort to bring it into alignment with the CPC+ measure set wherever possible.

Although the state had originally hoped to draw the data for this Scorecard from SHIN-NY and the APD, neither of these data sources is currently considered ready for this purpose. (See *Health information technology and data infrastructure, Section G.2.5* for details.) In the interim, the state has opted to hire a contractor to generate a subset of these measures using claims data provided by payers participating in the APC effort. These APC Scorecards are expected by state staff to be available to APC practices by early 2017. One payer felt this effort

Figure G-2. New York’s recommended payment model for primary care practices adopting the Advanced Primary Care model

G-17



Source: Gesten and Friedrich (2016).⁶⁵

APC = Advanced Primary Care; PMPM = per member per month; TA = technical assistance.

⁶⁵ Gesten, F., & Friedrich, M. (2016, April 4). APC webinar. New York State Department of Health. Retrieved from https://www.health.ny.gov/technology/innovation_plan_initiative/docs/2016-04-04_apc_webinar.pdf.

to provide practices with a more complete picture of their performance on a judicious number of quality measures for all their patients, regardless of payer, has the greatest potential to have a positive impact on health care in New York.

The most frustrating activity to New York SIM staff has been convincing the state’s DCS, which negotiates with state employee unions to make changes to the New York State Health Insurance Plan (NYSHIP), to employ more VBID principles, and possibly even to start offering APC practices new payments. “They’re dinosaurs,” one official told us. Changes to the state employee health plan also involve the Governor’s Office of Employee Relations and the state’s Division of Budget, “and each of them has their own angle on why doing the same old thing works.” Nevertheless, New York SIM staff remains undeterred and will continue to try to make progress on this front—partly to give the state more credibility when trying to convince other payers to make new APC payments. As this state official put it: “It’s frustrating because we’re out there telling everyone that [making APC payments] is the right way to go, and meanwhile we’ve got 1.2 million people in the NYSHIP program [for whom APC payments are not being made] and we’re stuck.”

G.3.5 Health information technology and data infrastructure

For health IT and data infrastructure undertakings, New York’s SIM Initiative incorporates two pre-existing health IT projects: SHIN-NY and the APD—both led by the Office of Quality and Patient Safety within NYSDOH. Eight regional health information organizations (RHIOs) facilitate the exchange of electronic health information at the regional level and enable connection to the SHIN-NY. The state also allows health care systems that have their own HIE to connect to the SHIN-NY. The SHIN-NY’s Statewide Patient Lookup feature enables providers to find patient records from across different regions. The SHIN-NY is operational, but continues to develop as the RHIOs grow in adoption and capability. SIM funds have been used to hire a consultant for the SHIN-NY’s infrastructure. Connectivity to SHIN-NY is an APC milestone Gate 3 practices are expected to meet.

In a related effort, the New York eHealth Collaborative, an organization involved in developing the SHIN-NY, is also developing a patient portal. State officials, however, did not attach much importance to this effort, citing lack of patient appetite for accessing portal information and the plethora of patient portals already available from providers and commercial payers. “We’re awash in patient portals,” said one state official.

New York began to develop its APD in 2012.⁶⁶ At the time of the site visit in May 2016, it was receiving data for Medicaid plans and plans sold through the state’s health insurance (ACA) marketplace and was scheduled to collect data for commercially insured patients by the end of 2016. New York SIM staff originally planned to use the APD as the data source for the

⁶⁶ New York State Department of Health. (2016, July). *Health Information Technology (Health IT): All Payer Database*. Retrieved September 14, 2016, from https://www.health.ny.gov/technology/all_payer_database/.

APC Scorecard, but the APD will not be operational in time, due to delays in front-end development and contracting for warehousing and analytics. State officials said the state is making progress on these fronts and aims to have the APD functional sometime in 2017. In the meantime, the state will move forward with a “Version 1” APC Scorecard that will rely on data collected by IPRO (a company), an external quality review organization with which the state already contracts on other quality measurement efforts. “Version 2” will draw from SHIN-NY and APD data, once these data sources are more mature.

The SIM health IT work group has been working on developing regulations for the SHIN-NY, APD, and the APC Scorecard. State officials noted that the work group’s multi-stakeholder composition has made it particularly helpful for developing policies around the “lightning rod” issues of consent, patient privacy, and data sharing. For example, after input from provider associations and consumer groups, the state decided the APD data would not be accessible to the public in the first year. SHIN-NY regulations were promulgated in fall 2015, and APD regulations were under development at the time of the May 2016 site visit. State officials noted that APD regulations will have to address the challenge of how to promote payer participation in the APD, as currently only Medicaid and ACA-qualified health plans are required to submit claims.

G.3.6 Workforce development

New York officials consider workforce development one of the primary drivers in achieving the aims of its SIM Initiative. As outlined in the state’s driver diagram,⁶⁷ New York’s workforce development strategy has four goals: (1) address emerging health professions needs, (2) ensure sufficient primary care workforce, (3) better distribute workforce to areas of need, and (4) train workforce for team-based care models. To that end, New York’s joint SIM- DSRIP Workforce Workgroup and its various subgroups plan to pursue efforts related to provider compensation, behavioral health providers, and care coordination.

A variety of respondents, both state officials and nongovernmental stakeholders, stated that successful deployment of the APC model depends on making advances in workforce development. Necessary advances include not only increasing the number of primary care physicians working in underserved areas of the state, but also defining the roles of nonphysician staff critical to team-based care and developing curricula in the state’s educational institutions that will train new providers and retrain existing providers to deliver the APC model to patients.

At the outset of the SIM Initiative, the most specific ideas for workforce development focused on increasing PCPs practicing in the state and improving their geographic distribution. SIM funds are being used to develop requests for application (RFAs) for a rural residency

⁶⁷ New York State Department of Health. (2015, December). *New York State SIM Year 2 Operational Plan*. p. 8. Retrieved September 14, 2016, from https://www.healthresearch.org/wp-content/uploads/2016/06/Year_2_Operational_Plan_12-24-15_Public.pdf.

program to bring medical residents into rural (non-teaching) hospitals, and a physician retention initiative to expose physicians trained in the state to opportunities to practice in upstate and rural areas, rather than staying in the urban areas in which they trained or leaving the state. The rural residency RFA has been drafted and is currently under review; the physician retention initiative RFA is still under development. Other medical education priorities under consideration for development with SIM funding include changing medical school admissions criteria for applicants interested in primary care, and providing incentives to increase the number of medical students choosing primary care rather than other specialties.

Key early activities of the work group were gaining a better understanding of the APC model and what it requires of the health care workforce. Members found the explanation the SIM staff provided to be useful, but both NYSDOH staff and work group members said they realized early on that they did not have the necessary data on the size and distribution of the current workforce to develop sensible strategies. Current sources of physician licensing data, for example, do not indicate whether licensed physicians are actively practicing, or even if they reside in the state. State officials intend to use the licensing provisions of the 2015 Nurse Practitioners Modernization Act as a model for future legislation governing other types of providers, including physicians and physician assistants. The licensing requirements for nurse practitioners have proved a rich source of information to identify the size, location, and scope of nurse practitioners' practices. At the time of the 2016 site visit, however, no such legislation for other provider types had been introduced.

New York's heavy focus on physician supply struck some external stakeholders as too narrow. At the time of the 2016 site visit, the primary focus of recent Workforce Workgroup activity had been defining the care coordinator role, since this new practice role will be instrumental to both practices adopting the APC model through the SIM Initiative and practices adopting the NCQA model through DSRIP. One external stakeholder asserted that the list of tasks the state has put forth as being integral to care coordination—rather than being performed by doctors—in fact seem likely to be passed down to lower-level workers. This stakeholder, therefore, saw a need for increased training of lower-level workers, who may well be called upon to perform care coordination tasks (e.g., placing follow-up calls to make sure patients understand their discharge instructions). Future work group meetings will discuss the educational requirements for persons able to provide care coordination and case management services, as well as the curricula necessary to train new providers of those services.

G.3.7 Population health

The state plans to influence the health of entire populations in regions of the state through public health efforts. While the state originally envisioned funding public health consultants to consult one-on-one with APC practices, and encouraging them to refer patients to social services in the community, the state had recently opted to modify this plan at the time of the May 2016 site visit; state officials were instead considering awarding SIM funds to a few communities

(such as through local health departments), to bring together key stakeholders from the public health sector, the local health care delivery system, and community providers of social services, to collectively address a common health improvement goal. This change was reportedly made out of concern that public health consultants, who would be “a single individual in the community,” would not be sufficient to meaningfully influence population health, and that there was a need to “broaden the scope” of this activity to create “multisector collaboration.” The latest thinking was that awardees would be charged with working with stakeholders in their community to develop a portfolio of interventions across all three of the Centers for Disease Control and Prevention’s (CDC’s) “buckets” of prevention: (1) traditional clinical prevention, involving increasing the use of evidence-based services; (2) innovative clinical prevention, involving delivering provider services outside the traditional clinical setting; and (3) total population or community-wide prevention, involving interventions that reach whole populations. This effort was still being formulated at the time of the 2016 site visit and yet to be finalized.

New York is also investigating the use of population health goals and strategies in other aspects of its SIM Initiative. For example, the APC Scorecard will include preventive population health measures, and the APC criteria that practices will have to meet to become Gate 3 practices include population health milestones.

G.3.8 Technical assistance and other support resources

State officials reported varying levels of utilization of CMS SIM TA. Those who used it said it was effective for obtaining guidance on specific issues. Multiple state officials said they found being put in touch with their counterparts in other states to be particularly helpful. One official said they found guidance delivered through the regular calls with CMMI helpful, too—specifically mentioning feedback from a CDC expert on the population health components of the state’s SIM Initiative. That said, not all feedback about CMS TA was positive—multiple stakeholders said they would like more help from CMS in engaging Medicare in the state’s SIM Initiative. State officials also expressed a desire for more CMS information sharing about lessons learned from Round 1 of the SIM Initiative and more input on aligning New York’s APC model with CMS practice transformation models.

G.3.9 Progress, challenges, and lessons

The area of progress most commonly mentioned in site visit interviews was reaching agreement among state and external stakeholders on the definition of the APC model. On balance, external stakeholders found state officials involved in the SIM Initiative to be highly capable and effective, and, for the most part, they reported the state was responsive to the concerns raised in work groups. The one note of dissent was from consumer advocates, who felt the state did not have a well-defined approach to consumer engagement and that, as a result, other stakeholders (particularly insurers and large providers) had more influence in the SIM Initiative. As of the May 2016 site visit, the other major areas of progress on the SIM Initiative

were establishment of the NYSDOH Innovation Center, engagement of multiple contractors, and development of requests for proposals to solicit bidders to assist with SIM implementation.

There was near universal agreement that moving from agreement on the definition of APC to adoption of the model by willing payers and providers will be a significant challenge. Some private insurers, for instance, expressed the sentiment that their existing approaches to value-based purchasing of primary care services already incorporate the basic elements of the APC model and often go beyond APC requirements. State officials acknowledged that these advanced arrangements exist, but felt unable to recognize pre-existing models for purposes of MLR adjustments or allowing plans to charge higher premiums. Officials also pointed out that pre-existing, value-based payment models were not as widespread as payers may claim. State officials planned to continue negotiations with insurers in an attempt to get them to commit to making APC payments to primary care practices that adopt the APC care delivery model.

The unwillingness of two very large payers in the state to participate in SIM activities is likely to be even more of a challenge. One of these is the state itself, through its NYSHIP. DCS manages NYSHIP, as noted earlier, and for decades the structure of employees' health insurance benefits (e.g., what is subject to cost-sharing and what size the co-pays are) has not changed, according to state officials. As noted, NYSDOH has tried to convince DCS to consider incorporating more VBID principles in the state employee health plan or to begin making APC payments, which would have to be negotiated with labor unions, but DCS has shown little interest in changing the status quo, according to NYSDOH officials. The RTI team tried to speak with representatives from DCS, but they chose not to be interviewed. The Governor's Office of Employee Relations and the state's Division of Budget also seemed uninterested in modifying the health plan according to state officials.

The other large payer missing from the New York SIM Initiative at the time of the 2016 site visit was Medicare. Some state officials felt that the new CMS CPC+ model could potentially deliver Medicare as a payer, if New York was selected by CMS to participate in this multi-payer medical home effort. Meanwhile, other interviewees expressed disappointment that CMS has so far been unwilling to consider making new Medicare payments to APC practices without making them meet CPC+ criteria. State officials felt that the APC care delivery model was highly consistent with the CPC+ care delivery model, and that requiring practices to meet both sets of standards to qualify for supplemental payments should be unnecessary if they had already met one of them.

Another major challenge to securing provider participation in the APC model, based on the focus group discussions, is that small practices seemed to have less interest in adopting the PCMH model of care,⁶⁸ making it potentially difficult to convince them to adopt the APC model.

⁶⁸ Raffoul, M., Petterson, S., Moore, M., Bazemore, A., & Peterson, L. (2015, April 1). Smaller practices are less likely to report PCMH certification. *American Family Physician*, 91(7), 440. Retrieved from <http://www.aafp.org/afp/2015/0401/p440.html>.

The regional approach to implementation of the APC model is New York’s primary tactic for dealing with these challenges—that is, implementing the model first in those geographic areas in which willing providers, insurers, and purchasers all exist.

Finally, several interviewees identified the recent failure of Health Republic as a challenge. Their main concern, as noted, is that legislative action could potentially relieve DFS, which approved premiums for the Health Republic plan, of its role in approving health insurers’ annual premium increases more broadly—thus removing one of the main policy levers available to the state to incentivize payer participation in the APC model. Many state officials, however, did not believe this would come to pass. Since the site visit, the 2016 legislative session has closed and did not pass such a measure, though state officials cautioned that it could be revisited in the future.

Interviewees identified several lessons learned in the course of SIM Initiative implementation to date. First, there was general agreement that data collection is a prerequisite for making informed workforce decisions, and that the data available at the beginning of the SIM Initiative were insufficient. State officials also noted that it would have been helpful if CMS had shared some lessons learned from case studies from SIM Round 1 Model Test states, so Round 2 states could learn from those experiences. Third, interviewees identified the importance of broad stakeholder participation from the beginning, as a necessary condition for reaching agreements; open communication between the state and stakeholders beyond scheduled meetings; and state willingness to use specialized work groups on an *ad hoc* basis.

Finally, state officials cautioned that change takes time, so expectations for quick transformation should be tempered. Specific time-consuming activities interviewees mentioned included a state official warning that it takes time to negotiate contracts with insurers, and a payer noting that it takes time to set up a care management department in practices.

G.4 Statewide Changes

G.4.1 Health care expenditures, utilization, and quality

As mentioned above, stakeholders consistently commented that health spending in New York is high compared to other areas of the country. Interviewees also described quality of care as low and, moreover, not commensurate with the level of spending. In addition, stakeholders described New York as having a highly hospital-centric health care system.

Many interviewees viewed successful implementation of the APC model as the single most promising element of the SIM Initiative for reducing growth in health care spending in the state. Stakeholders expected that emphasizing primary and preventive care and promoting care coordination in the APC model will change utilization patterns, and that more care will be delivered in an ambulatory setting and less in more costly health care settings, such as hospitals. A New York official was explicit that the SIM Initiative will not bring about an “actual

reduction” in spending, but said the state hopes it will bring about a four percent reduction in spending growth, which would amount to “a lot of money” and be “a success.”

Related to this, some stakeholders viewed SIM-related efforts around measure alignment as holding considerable promise in affecting quality and ultimately costs. Others viewed furnishing providers with quality measure data for all their patients through the APC Scorecard, regardless of payer, as having the potential to change physicians’ care delivery patterns and improve care quality. Still others thought that no particular piece of the SIM Initiative will lower costs, but rather, according to one stakeholder, the pieces are “all part of a continuum, so it is hard to say any one project has greater bearing than others.”

Some stakeholders viewed improvement in quality of care as a potential “early win,” although others cautioned that quality does not “change overnight” and that measuring and documenting progress is critical. Some viewed lower health care cost as a longer-term outcome. While describing the SIM Initiative goals as “all lofty and good,” a few stakeholders worried that the APC model, as currently envisioned, is not sufficient, particularly in its ability to engage consumers. As one stakeholder put it, the APC model is a “really mediocre, low-ball APC model,” in that “real, meaningful engagement of consumers” was not required to occur until Gate 3 of the APC model.

G.4.2 Care coordination

Many state officials, payers, and providers felt that, despite the state’s claim in its SIM application that it leads the nation in the number of primary care practices that had obtained formal certification as a PCMH, New York is actually behind many states in the extent to which care coordination truly exists in their health care system. At the same time, stakeholders noted that this is changing. Moving to a more coordinated system of care was described as a “slow shift” but “they are moving in the right direction.” Stakeholders also mentioned that some providers (physicians and hospitals alike) are doing very well financially under the current fee-for-service payment and delivery system and are not interested in pursuing a model like that of the APC. Others, however, highlighted areas in the state where considerable care coordination already exists, but that such coordination is very regionally based.

Many interviewees viewed successful implementation of the APC model as critical to seeing an impact on care coordination and as being intertwined with lowering costs, changing utilization patterns, and improving quality of care. Some interviewees also viewed workforce efforts taking place under the SIM Initiative as important to improving care coordination, especially for delivery of care to high-risk patients.

G.4.3 Population health

Stakeholders had mixed views of what population health means and where New York stands on this dimension of health. If measured in terms of managing populations of people with

diabetes or asthma, New York is already doing this, according to interviewees. But if population health is taken to refer to improving the health of entire geographic populations, New York is behind.

Expectations about what success in pushing forward population health would look like varied across stakeholders, in part because of the different perceptions of the term itself. One interviewee thought the APC model includes measures of population health (e.g., diabetes, asthma, tobacco cessation); to this person, improvement in these measures would be a population health success. Another mentioned that if APC-certified practices were aware of, and referred more of their patients to, community-based programs and social support services (e.g., supportive housing or addiction services), that would be a measure of success in improving population health. Still others felt that, apart from lowering the total cost of health care, success in population health would be improved consumer engagement, participation, and knowledge about their own health care.

G.5 Overall New York Summary

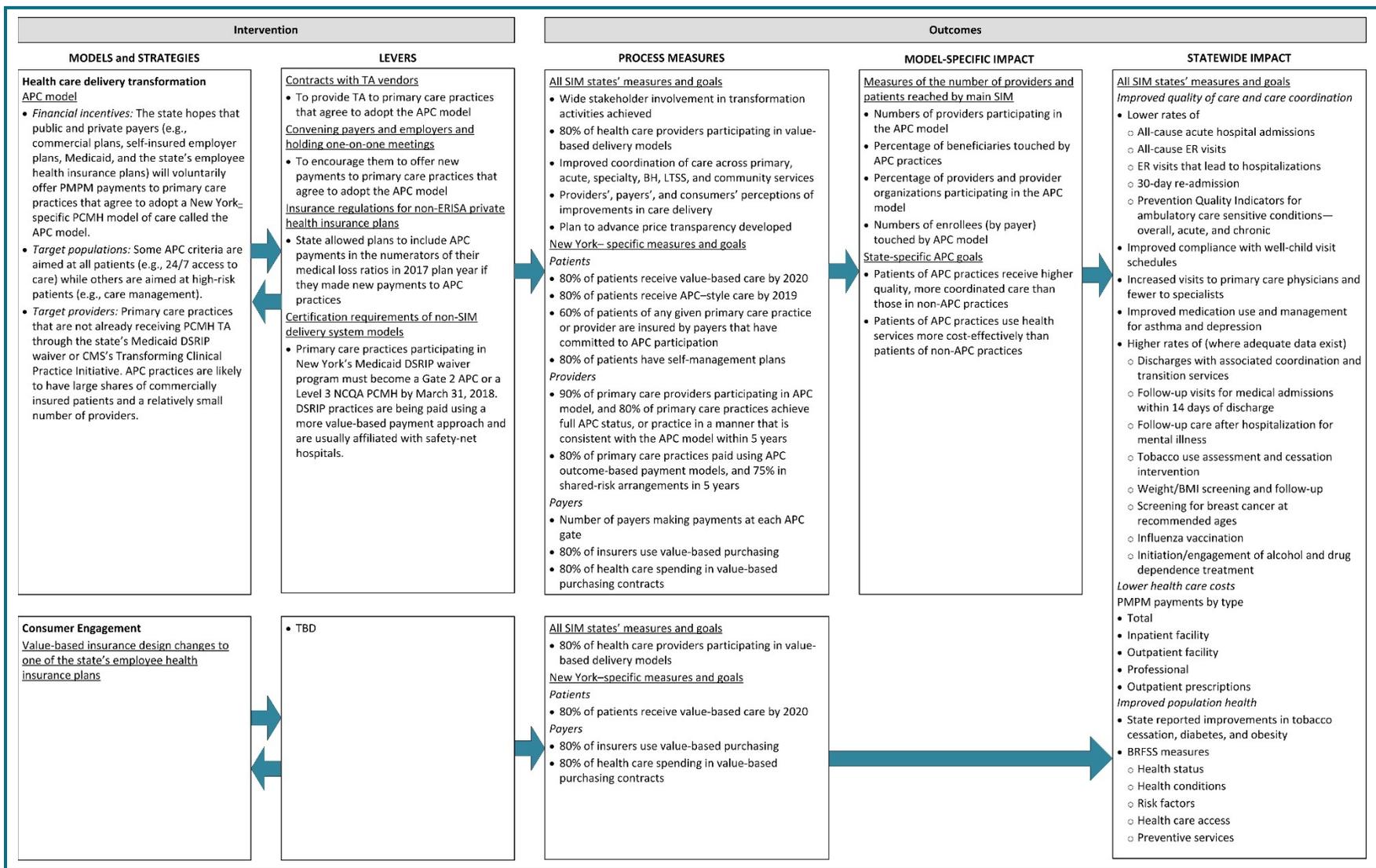
Since receipt of the SIM award, New York completed many important, logistical activities, including (1) forming and staffing a new NYSDOH office to lead the New York SIM Initiative; (2) contracting with various vendors to assist with SIM implementation; and (3) quickly forming, repurposing, or sharing work groups and using them to generate active and sustained engagement from both external stakeholders and a wide range of state staff representing different agencies. Another major accomplishment was the state's fleshing out and refinement of its APC care delivery model, while taking into account feedback from a range of stakeholders—the main focus of the state's SIM Initiative in its first year. Most interviewees said state staff leading the SIM Initiative earn kudos for being receptive to feedback and balancing diverse perspectives, although consumer advocates felt their views have been under-represented.

New York's greatest challenge moving forward on the SIM Initiative has been convincing payers to make changes to their health insurance plans—either to offer new payments to practices that adopt the APC model of care, or to change the design of health benefits to incorporate VBID principles. At the time of the May 2016 site visit, no payer had formally committed to making any of these changes, but state staff remained sanguine and intended to continue these efforts in SIM's second year. Although modifying the state employee health plan appeared more of a longshot, encouraging signs suggested that New York might be able to convince some private payers to participate in the APC model. As an example, one payer applied to serve as a regional APC TA vendor, suggesting to state staff that the payer is likely to pay at least some of its contracted providers new APC payments. Another indicator taken as promising was that three payers responding to DFS's 2016 payer survey said they were ready to begin offering APC payments in 2017, and a fourth said it would be ready to do so in 2018.

Because payers are not required to participate in the APC model and can decide the size, structure, and timing of any new payments to practices, the risk is that payers will choose not to offer payments to practices until they are 1 or 2 years into their APC transformation journey. This timeline could pose a problem for practices, because they will have to come up with the up-front costs for things like hiring a care coordinator, upgrading an EHR, reallocating existing staff labor to participate in APC TA activities, and making changes to practice workflows and protocols.

Payers and providers in New York each seem to be waiting for the other to embrace the APC model before they agree to support it. Based on the RTI team's interviews, payers do not want to start paying practices new APC payments until practices have partially or fully adopted the APC model, while practices do not want to start adopting the APC care delivery model unless payers are willing to pay them for the time and expense involved in doing so. Whether payers and providers buy in to the APC model is yet to be seen, but its resolution is a crucial step if the state is to move forward with implementation of the APC model, since either providers or payers will end up taking on a near-term financial loss before longer term financial gains begin to accrue to both parties.

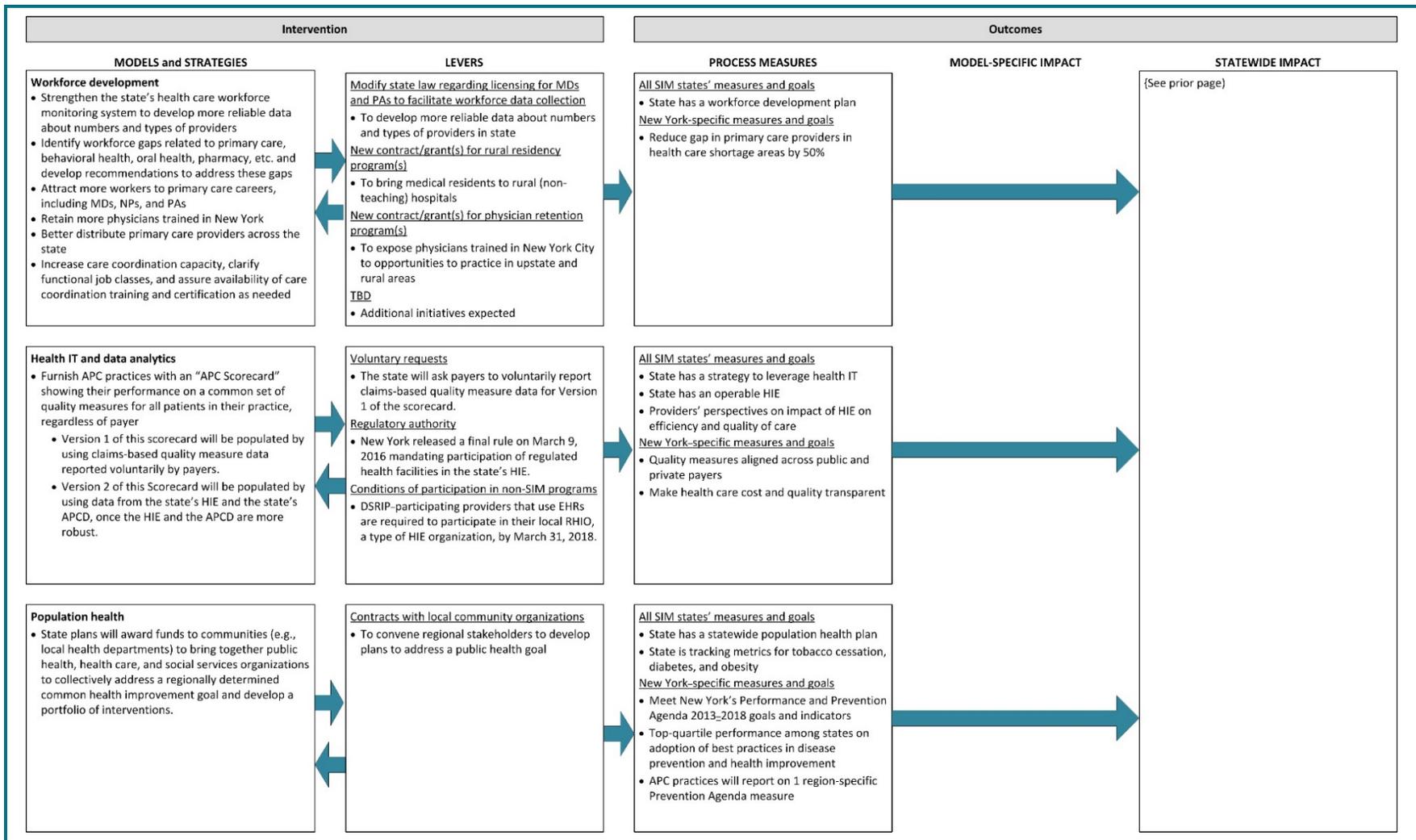
Figure G-3. Logic model for New York’s State Innovation Model activities



G-27

(continued)

Figure G-3. Logic model for New York’s State Innovation Model activities (continued)



G-28

APC = Advanced Primary Care; APCD = all-payers claims database; BH = behavioral health; BMI = body mass index; BRFS = Behavioral Risk Factor Surveillance System; DSRiP = Delivery System Reform Incentive Payment; EHR = electronic health record; ER = emergency room; ERISA = Employee Retirement Income Security Act; health IT = health information technology; HIE = health information exchange; LTSS = long-term services and supports; MD = medical doctor; NCQA = National Committee for Quality Assurance; NP = nurse practitioner; PA = physician’s assistant; PCMH = patient-centered medical home; PMPM = per member per month; RHIO = regional health information organization; SIM = State Innovation Model; TA = technical assistance; TBD = to be determined.

Appendix H: Ohio Site Visit Report

The Ohio site visit took place from June 13 through June 16, 2016, during which the RTI team conducted 12 in-person interviews (11 in Columbus and one in Cleveland). The team also conducted four interviews by phone prior to the visit, one during the visit, and one afterward, for a total of 18 interviews. Interviewees included state officials, payers, primary care providers (PCPs), medical association representatives, and consumer advocates. In addition, the team conducted four focus groups in Cleveland. Two were with consumers (one with Medicaid beneficiaries with multiple chronic conditions and one with Medicaid beneficiaries attributed to Wave 1 episodes of care [EOCs]); and two were with providers (one with primary care physicians and one with likely principal accountable providers [PAPs] for EOCs implemented early in the Ohio SIM Initiative).

This appendix provides an overview of the Ohio SIM Initiative; describes the current health care context in which the SIM Initiative is being implemented; summarizes early implementation successes, challenges, and lessons learned; and discusses key findings from the site visit interviews and focus groups organized by major topic area. This appendix includes findings based on qualitative data collected through June 30, 2016. Further details on the analytic approach are available in *Appendix L*. Information on the site visit interviewees for the state is in *Table L-1*, and information on the provider and consumer focus group participants for the state is in *Tables L-4* and *L-5*, respectively.

H.1 Overview of Ohio's State Innovation Model

In 2011, Ohio was awarded a SIM cooperative agreement to systematically convert its health care delivery system to person-centered models that engage patients in decision making, involve providers in integrated delivery models, hold providers accountable for quality and cost of care, and link payments to value. The Ohio SIM Initiative was launched in 2014, with the goal of enrolling 80 percent to 90 percent of residents and 50 percent of health care spending in a value-based payment model within 5 years.

Ohio aims to achieve this goal through two key strategies:

- ***Patient-centered medical homes.*** Starting in 2016, Ohio will implement patient-centered medical homes (PCMHs) statewide, instead of their original phased regional roll-out plan. Ohio believes this acceleration of the roll-out of PCMHs will better help them reach their goal of a minimum of 69 percent of patients receiving care through PCMHs by 2019. While commercial insurer participation will be voluntary, Medicaid managed care plans must recognize PCMHs.
- ***Episodes of care.*** Ohio plans to develop up to 50 EOCs. Episodes will hold one provider accountable for total cost and quality of care, with incentive payments tied to performance. Like the PCMH program, commercial insurer participation will be voluntary, but Medicaid managed care plans must use the EOCs the state establishes.

Stakeholders agreed with the choice of PCMHs and EOCs as the key initiatives to transform the health care system. No other initiatives were seriously considered by the state. For example, according to interviewees, focusing on developing accountable care organizations (ACOs) was thought too big a change for the Ohio health care system to accept. State officials see the EOCs and PCMH initiatives as important on their own and consistent with several possible reform strategies. As one state official pointed out, “Both PCMH and EOCs can be fit into other models, implemented regardless of provider structure, and be ‘carved out or ‘carved in’ for ACO or capitation.”

Ohio is also engaged in initiatives related to health information technology (health IT), workforce development, and population health. The population health activities are explicitly linked to the PCMH initiative.

H.2 Logic Model

Figure H-1, located at the end of this appendix, depicts the logic model for Ohio’s SIM Initiative, including the hypothesized relationships between the SIM Initiative and outcomes. Column 1 describes the key health care delivery transformation models: EOCs, and PCMHs. It also describes the strategies in workforce development, health IT, and population health. Column 2 outlines the levers by which Ohio will implement these models and strategies. These two intervention columns are closely intertwined, as seen by the arrows pointing in both directions.

Columns 3 through 5 outline the intended outcomes of the SIM Initiative. Column 3 presents the process measures for the initiatives. EOCs and PCMHs aim to have both model-specific (Column 4) and statewide (Column 5) impacts. As seen in Column 5, these models are expected to improve statewide quality of care and care coordination, lower health care costs, and improve population health.

H.3 Implementation Activities

H.3.1 Context of health care system

Ohio has a population of 11.5 million residents in seven metropolitan areas and 50 rural counties. Like many other states, Ohio’s health care delivery system is fragmented in ways that include misaligned incentives, lack of coordination across providers, and uncoordinated relationships between providers and patients—all of which lead to high costs and inadequate quality of care. Unlike some other states, however, the state’s insurance market is highly competitive, with no health insurer having more than 20 percent of the market.

Stakeholders saw Ohio as dominated by large, health systems in major markets and historically driven by fee-for-service (FFS)-based care. Although Cleveland, Columbus, Dayton, and Cincinnati are important urban centers, many interviewees stressed the importance of the needs of the rural population in the state’s Appalachian region.

Stakeholders also had a general understanding that Ohio spends significant amounts of money on health care, more than most states per capita, but continues to see poor overall population health outcomes. According to an analysis by the Health Policy Institute of Ohio,⁶⁹ Ohio ranks in the bottom quartile of states and the District of Columbia in population health, in the top quartile in health care costs, 44th in adult smoking and in avoidable emergency room (ER) visits for Medicare beneficiaries, and 47th in infant mortality. Multiple interviewees identified infant mortality, smoking, and ER utilization as areas that need to be addressed to improve the overall health of Ohioans and reduce the rate of growth in health care spending.

Stakeholders commented on how the metropolitan and rural areas require different supports for transformation and on the challenges Ohio faces in preserving its rural health care providers. As one purchaser reflected, “When you have a lot of nonintegrated systems in rural areas that are very established in traditional fee-for-service based care, it means you get a lot of volume at higher cost. When you look at our state health rankings, you see that we pay a lot more and do not get that much more quality. Until we align incentives to achieve outcomes, we won’t get the outcomes we are looking for.”

Providers also reflected positively on the strengths of the Ohio health care landscape, citing strong medical schools that draw high-quality practitioners to Ohio’s health care markets. Because of the well-known medical schools (e.g., Case Western University, Ohio State University) and internationally known health care providers (e.g., the Cleveland Clinic), stakeholders felt that Ohio has some of the world’s best medical care practitioners. Another strength stakeholders noted was that, because the state has expanded Medicaid eligibility, uncompensated care has gone down for hospitals, freeing up funds to invest in upstream preventive and primary care services.

Both payers and providers noted the challenges—including poor patient compliance and overutilization of the ER—of serving the Medicaid population. One provider at the focus group noted that a recent influx of Hispanic and Somalian immigrants in some areas of the state has increased the need for interpreters and training focused on cultural competency. Two other providers reflected that their offices do not have the staff or time to fully address the needs of these new populations and that interpreters often are not available.

Other health reform initiatives

Ohio government has extensive involvement in health reform initiatives. In 2011, the Governor created the Office of Health Transformation, in the Governor’s Office, to pursue three aims: (1) modernizing Medicaid, (2) streamlining health and human services, and (3) improving Ohio’s overall health system performance. An important objective of the Governor’s effort has been to slow the growth of Medicaid spending. In addition to expanding Medicaid to more low-

⁶⁹ Health Policy Institute of Ohio. (2014, December 16). *2014 Health Value Dashboard*. Columbus, OH. Retrieved from <http://www.healthpolicyohio.org/2014-health-value-dashboard/>.

income Ohioans and streamlining Medicaid eligibility determinations, the Governor's plan to modernize Medicaid includes prioritizing home and community-based services, integrating Medicaid and Medicare benefits, creating health homes for people with mental illness, and improving Medicaid managed care. In 2013, Medicaid became a stand-alone, cabinet-level department, reporting directly to the Governor.

In 2012, the state notified federal officials that Ohio would pursue a federally facilitated insurance Affordable Care Act (ACA) marketplace but would maintain regulatory control over participating insurance providers. Ohio is one of seven states to receive approval from the U.S. Department of Health and Human Services to conduct plan management activities to support certification of qualified health plans in the federally facilitated marketplace.

In 2013, Ohio chose to expand Medicaid coverage through the ACA, and over 285,000 people have enrolled. Ohio's decision to expand Medicaid triggered the formation of a grassroots coalition of health care stakeholders spanning chambers of commerce, faith-based organizations, consumer-advocacy groups, local governments; and health care providers, systems, and payers. The Office of Health Transformation relies on this large coalition to quickly share information and seek feedback on emerging policy priorities, like the SIM Initiative. In addition to expanding Medicaid coverage, Ohio is working to streamline its enrollment process for health coverage under the ACA, although not under SIM. Individuals can apply for both Medicaid and health insurance marketplace coverage through multiple pathways, including in person, over the phone, by mail, and online. Ohio also developed a new Web site from which users can access a variety of services—including Medicaid; food stamps and cash assistance; and Women, Infants, and Children nutritional assistance, among others.

Concurrent with the SIM Initiative, Ohio is participating in a very large number of other federally funded health care innovation activities (see *Table H-1*). The Office of Health Transformation aims to align these and other private and public sector health innovation activities, to avoid duplication of efforts and conflicting quality measures between the SIM Initiative and other initiatives.

Table H-1. Ohio’s involvement in non-State Innovation Model Initiative federal health reform initiatives

Name of initiative	Description of initiative
CPCi	Operating in southwest Ohio, this initiative seeks to strengthen primary care, by offering care management fees to coordinate care and shared-savings opportunities to participating primary care practices.
MPIP	MPIP provides incentive payments to help health care providers make the conversion to EHRs.
Financial Alignment Initiative	MyCare is the Ohio name for a demonstration project aimed at coordinating medical and LTSS financing and delivery, for Medicare-Medicaid beneficiaries. This is a collaborative effort among Ohio Medicaid, CMS, and five private managed care plans.
Medicare BPCI Initiative	BPCI is a Medicare payment initiative that links payments for multiple services during an EOC. Under the initiative, organizations enter into payment arrangements that include financial and performance accountability for EOCs.
BIP	BIP is an ACA provision that provides a higher federal medical assistance percentage for home care in exchange for making certain LTSS infrastructure improvements.
MFP	Part of the federal MFP program, Ohio’s HOME Choice program transitions eligible Ohioans from institutional settings to home and community-based settings.

ACA = Affordable Care Act; BPCI = Bundled Payments for Care Improvement; BIP = Balancing Incentive Program; CMS = Centers for Medicare & Medicaid Services; CPCi = Comprehensive Primary Care initiative; EHR = electronic health record; EOC = episode of care; HOME Choice = Helping Ohioans Move, Expanding Choices; LTSS = long-term services and supports; MFP = Money Follows the Person; MPIP = Medicaid Provider Incentive Program.

A few stakeholders, including state officials and payers, noted that the next Ohio gubernatorial election could affect the sustainability of SIM-related activities, because the current Governor is in his second and last term. With less than 2½ years left before a change in administration, some observers expressed concern that the health care transformation initiatives embraced by the current Governor, including the SIM Initiative, might not be supported by his successor. One state official noted, “Political change is a huge risk factor, looking at some other states that made huge investments in going the value route.”

Stakeholders were uncertain how the SIM Initiative might be affected if Ohio is selected for Comprehensive Primary Care Plus (CPC+), a national, advanced, PCMH model that aims to strengthen primary care through regionally based, multi-payer payment reform and care delivery transformation. The multi-payer payment redesign is expected to give practices greater financial resources and flexibility to make appropriate investments to improve the quality and efficiency of care, and reduce unnecessary health care utilization. CPC+ would provide practices with a robust learning system, as well as actionable, patient-level cost and utilization data feedback to guide their decision making.

The CPC+ initiative opportunity took Ohio by surprise and forced a reevaluation of its PCMH activities; but the state has fully embraced it and applied to be one of the demonstration regions. If Ohio is selected as a CPC+ region, the Office of Health Transformation intends

Ohio's SIM Initiative PCMH program to align with CPC+. However, at the time of the 2016 site visit, stakeholders were generally uncertain about how CPC+ would integrate with the SIM Initiative.

H.3.2 Governance and program administration

The Office of Health Transformation leads the Ohio SIM Initiative, providing oversight on behalf of the Governor, directing and coordinating state agency efforts with the private sector and stakeholders. Ohio's SIM agency leadership is organized through the SIM Directors Group, which includes leaders of the Office of Health Transformation, the Ohio Department of Medicaid, the Ohio Department of Health, the Department of Mental Health and Addiction Services, and the Department of Administrative Services (which is responsible for state employee health plans). Some stakeholders, inside and outside government, felt that having the Office of Health Transformation already in place with goals that aligned with the SIM Initiative enables good governance, coordination, and support for health care transformation.

The Ohio Department of Medicaid is responsible for implementing the key SIM strategies of EOCs and PCMHs for Medicaid, administers SIM funding, and connects the SIM Initiative to other Medicaid initiatives. Compared to many other states where the legislature must approve detailed spending decisions and key policy decisions, the Ohio Department of Medicaid has considerable discretion to implement changes.

State officials and staff generally said they believe they have sufficient state and federal resources to implement the SIM Initiative. However, during the June 2016 site visit, state officials expressed concerns that they could not obtain an advance of future federal funding for the state-initiated acceleration of their EOC initiative. One state official noted that, "By accelerating these [EOCs] forward, we get efficiency However, the way the federal budget works, we cannot pull forward those funds [to support their development]. Therefore, we cannot pay for it [out of the federal funds]. We made a decision that this was important, so we are using our own money. We think that by the end of the project, we will have been able to recover the state's expenses."

H.3.3 Stakeholder participation

The Office of Health Transformation has engaged diverse stakeholders in the design and implementation of the SIM Initiative in several ways—establishing numerous external work groups, convening many meetings, holding focus groups with providers, and conducting a survey of PCPs. Given the commitment of the Governor to nonregulatory approaches to health transformation for non-Medicaid providers and insurers, buy-in is key to voluntary implementation by these stakeholders.

The Governor's Advisory Council on Payment Innovation, the multi-payer SIM Core Team, and the SIM EOC and PCMH design teams, all of which include private sector partners, play important roles in the design and implementation of the SIM Initiative.

The Governor's Advisory Council—established in 2013 prior to the SIM Initiative, and comprising purchasers, plans, providers, consumers, and researchers—has met periodically to advise the state on priorities for and coordination of multi-payer, health care payment innovation activities statewide. The Council also recommended experts to participate on the committees that advise the SIM Initiative.

The SIM Core Team—which consists of the major insurers (Aetna, Anthem, Buckeye, CareSource, Medical Mutual, Molina, Paramount, and United)—aligns overall strategy across payers. These insurers together account for 80 percent of the insured population in Ohio. The chief executive officers of these Medicaid and commercial plans have committed to the Governor that they will help design and implement EOC and PCMH models in Ohio, although not necessarily exactly as they will be implemented for Medicaid. The EOC and PCMH teams, made up of clinicians and payer representatives, have led development of the two models and the work of related focus and advisory groups.

The PCMH and EOC design teams include representatives of key state agencies; provider organizations representing various geographic areas, level of scale, and integration; purchasers representing self-insured employers; payer experts; and payment innovation leaders from across the state (e.g., community leaders, local collaboratives, health IT experts, and research organizations). Heavily involved in the design phase, these teams work with the Office of Health Transformation to coordinate implementation of initiatives, share lessons learned, and inform improvement.

The PCMH and EOC design teams were established to provide feedback and clinical expertise on the SIM Initiative. For PCMH, three focus groups were convened: (1) high functioning care providers, (2) patients and advocates, and (3) payers. These focus groups, along with the survey of PCPs, played an instrumental role in the design of Ohio's PCMH program. The EOC design team convened specific clinical advisory groups, comprising relevant physician and other clinical experts, at the beginning of each episode design phase. Going forward, the state intends both design teams to be sounding boards on how to refine the Ohio SIM Initiative.

To broaden engagement, the Office of Health Transformation also held open forums to solicit feedback from providers, as well as sponsored educational webinars focused on the mechanics of, and broader importance of, PCMHs and EOCs to the provider community. State officials indicated that they continue to hold learning sessions and one-on-one conversations with payers, and continue to solicit consumer feedback.

Participating stakeholders stated their general belief that state SIM leadership values their input. Many stakeholders cited the Governor’s Advisory Council and the three SIM leadership design teams—the multi-payer core team, and the PCMH and EOC design teams—as important and helpful vehicles for convening key stakeholders, some of whom had not worked closely together before, to collaborate on transformation. Payers and providers commented positively that the design teams have facilitated the ability to solicit input to develop a comprehensive plan.

However, some stakeholders contended that, while the initial engagement on the overall design was purposeful and well-coordinated, subsequent phases of work involving implementation could have provided more opportunities for input. One provider reflected, “The process has been good from an outreach perspective. The SIM Initiative has done a good job reaching out to the provider community, payer community, and patients groups. In subsequent phases, which we are just now entering, there is less thought put forward to how you continue to have meaningful check-ins to see if the state is on the right path.” Initial open stakeholder meetings were intended to obtain input and support for proposed initiatives.

As the SIM Initiative was implemented, the work groups and SIM Core Team began focusing on specific design elements of EOCs and details surrounding implementation. This implementation phase also engaged consultants, such as McKinsey & Company (McKinsey), which conducted the data analyses needed to operationalize the EOCs (e.g., establishing the cutoff points for eligibility for financial incentives). As the SIM work evolved, some consumer advocates felt that they do not have as many opportunities to provide input as health plans and providers did. These advocates also believed their perspectives do not carry the weight of some other stakeholders.

Ohio officials acknowledged that engaging diverse stakeholders is challenging. They noted that interactions with providers sometimes can be contentious, especially the changes affecting reimbursement. Both providers and consumer advocates expressed concern about ensuring support for and representation from rural communities and providers during SIM implementation, particularly around preserving small, independent practices that may not be able to transform as easily as their larger, and more urban, counterparts. Although generally supportive of the state’s efforts, some stakeholders observed that the state’s contractor, McKinsey, seemed especially influential in designing the EOCs and other components of the SIM Initiative, perhaps because of the model’s very technical requirements. In its approach, McKinsey drew heavily from models it had developed for Arkansas and other states. A payer also noted, “The state relies very heavily on consultants. Often times, regardless of feedback from stakeholders, they have their mind made up on how everything is going to work. Even though you have the opportunity to provide feedback, I am not sure there is always that opportunity to affect the outcome.”

H.3.4 Delivery systems and payment reforms

EOCs and PCMHs are Ohio's two main delivery system and payment reforms under the SIM Initiative. Although there are clear and intended overlaps between the two initiatives, EOCs are targeted more at specialists, and PCMHs more at PCPs.

Patient-centered medical homes

Ohio is working to reinvent primary care and make it central to the health care delivery system by promoting PCMHs. Prior to the SIM Initiative, Southwest Ohio had participated in the Comprehensive Primary Care initiative (CPCi), and multiple PCMH pilot projects were taking place throughout the state. During the state's SIM Model Design period, Ohio's multi-payer coalition created a PCMH charter outlining desired levels of alignment across four elements of the PCMH model: (1) care delivery, (2) payment model, (3) infrastructure, and (4) scale up and practice performance improvement. All payers agreed to align, in principle, with the four elements of the model but have implemented their own designs.

Ohio has worked to make its PCMH model flexible enough to meet the needs of different types of providers and geographic areas, as well as to encourage participation by as many practices and patients as possible. For example, accreditation by particular professional groups and the use of specific tools, such as electronic health records (EHRs), are not required. Moreover, exactly how much insurers should pay PCMHs is left to the discretion of each payer.

The lack of detailed requirements for participation was designed to attract the most advanced and least advanced practices. Participation in Ohio's PCMH program is voluntary for practices—an approach stakeholders saw as a critical feature in engaging a wide range of practices from small, solo, and rural practices to the large, urban health systems in Ohio.

The Ohio PCMH care delivery model envisions four stages a practice may go through to become a transformed primary care practice: beginning, early, maturing, and mature. This “journey,” which is mapped around 11 domains that span different facets of care delivery, is intended to serve as a transformation guide for participating practices. Practices further along in their transformation will be rewarded financially for better outcomes.

At the time of the 2016 site visit, some details of the state's program were still being worked out, but the general approach had been established. To join the state's PCMH program, practices must apply and meet enrollment requirements in three domains: eligible provider type; minimum size of 5,000 attributed or assigned Medicaid patients; and commitment to PCMH practice transformation. Practices whose applications are accepted and who meet the enrollment requirements will have access to two nonfinancial benefits: (1) recognition as a state-designated PCMH, which could help attract new patients; and (2) access to data and reporting that provide actionable, timely information that practices can use to make better decisions about outreach, care, and referrals.

All practices will have access to two new payment streams: (1) per member per month payments tied to meeting activity, efficiency, and clinical measurement requirements; and (2) shared-savings payments for achieving total-cost-of-care savings, either through self-improvement or relative to peers. Some practices also may be eligible for a one-time, practice transformation support payment to help them begin to transition to a PCMH.

Building on the CPCi experience, the PCMH design team created a baseline set of requirements, making modifications as needed. Changes reflect adaptations to make the PCMH model accessible to primary care practice types with different baseline capabilities in care coordination and population health management. Proposed model elements also were informed by extensive claims-based analytics to test the impact of proposed definitions, particularly for attribution and payment. To build cross-payer alignment on PCMH quality metrics, the Office of Health Transformation convened a quality metrics working team consisting of Medicaid FFS providers, Medicaid managed care plans, and commercial payers. To achieve alignment, the working group agreed on a collaborative process between payers and providers, creating a set of guiding principles to inform the selection of requirements. To be considered, measures had to be recognized (i.e., nationally accepted, with priority for measures already in use by Ohio programs), effective (i.e., giving priority to outcomes over process), and inclusive (i.e., relevant to all practices, covering all demographic groups, and aligning with Ohio population health priorities). The selected PCMH quality measures address preventive care, appropriate care, and behavioral health, and cover all population groups.

In 2015, the Office of Health Transformation and the Ohio Department of Medicaid of Medicaid decided to accelerate the implementation timeframe originally proposed for the PCMH SIM test period. Instead of a 3-year regional rollout, the state decided to implement the PCMH model statewide, starting in 2016. At the time of the 2016 site visit, officials expected to begin statewide rollout in January 2017 with more advanced practices, and open to all primary care practices statewide in January 2018. According to state officials, the delay is partly attributable to the assessment and work that went into applying for the CPC+ demonstration and to related adjustments required in the PCMH model.

In June 2016, the Ohio Department of Medicaid proposed a new regulation that will set the Medicaid policy and payment infrastructure for PCMHs. All Medicaid managed care plans will be required to offer PCMH payments to participating practices. At the same time, the Ohio Department of Medicaid submitted a state plan amendment to CMS to authorize a primary care case management program—as a vehicle to provide payments to practices for activities that improve care; outcomes-based payment for achieving total-cost-of-care savings and meeting predetermined quality targets; and for some practices, one-time practice transformation support to help them successfully begin the transition to a PCMH. Ohio has built time into its PCMH implementation schedule to account for CMS review of this state plan amendment. Ohio is hoping the review will be approved in a timely and efficient manner, so the state can achieve its

accelerated timeline. Based on discussions with CMS, Federally Qualified Health Centers will not be able to participate in the Ohio Medicaid PCMH program, because of inconsistencies with federal reimbursement rules on these providers.

In general, interviewed payers responded favorably to the implementation and design of Ohio's PCMH model. Because Ohio had already participated in CPCi in southwest Ohio, some payers were familiar with the model. One payer noted, "The PCMH process started back in the 2000s, where there was federal money out there for providers who wanted to move into an NCQA [National Committee for Quality Assurance] designation and EHRs. This brings an organized framework for more PCMH practice transformation."

Some payers expressed excitement to see the momentum behind EOCs and PCMH, whereas other stakeholders noted that PCMH models had been used in the state before without much impact. A common theme throughout the payer interviews was that full success requires integration between EOCs and PCMHs. One payer noted, "There is an interplay between the providers in the EOC model and the providers in the PCMH model. Those providers need to work together and communicate." Another aspect of Ohio's PCMH model that payers responded favorably to is that the state has allowed space for individuality and innovation for PCMH-participating practices. Payers generally felt that the model allows for providers to make independent decisions about the care of individual patients. Overall, payers believed PCMHs will have a long-term positive impact on health care delivery in Ohio.

Episodes of care

Ohio's episode-based payment model seeks to encourage high-quality, patient-centered, and cost-effective care by holding a single provider or entity accountable for care across all services in a single episode. Providers whose episodes meet quality metrics and are substantially below average cost will be financially rewarded; providers whose episodes are substantially above average cost will have their reimbursement reduced. Although there is an initial informational reporting period, reimbursement incentives are based on 1-year, look-back periods, creating a significant lag between performance and reimbursement changes. As noted, while Medicaid managed care plans are required to implement the EOC system in the manner specified by the state, participation by commercial insurers is voluntary—although they have promised to implement the episodes in a manner roughly consistent with how they are designed for Medicaid.

Ohio's multi-payer coalition created an EOC charter to determine levels of payer alignment across three main elements:

- ***Accountability.*** Within each EOC, a PAP identifies the provider best positioned to assume accountability for the episode, based on such factors as decision-making responsibilities, influence over other providers, and portion of the episode expenditures.

- ***Retrospective payment model.*** A retrospective approach is taken to calculate incentive payments and reward cost-efficient, high-quality care. That is, payment adjustments are made to past reimbursements to the provider. Claims-based metrics are used to evaluate the quality of care during each episode and linked to the financial incentives.
- ***Positive and negative financial incentives.*** After making certain exclusions, payers calculate the average, risk-adjusted reimbursement per episode for each PAP and compare results to predetermined “commendable” and “acceptable” levels. PAPs may receive shared savings, if their average costs are in the commendable levels and quality metrics are met. If average costs are above the maximum acceptable level, PAPs are subject to negative payment incentives (reimbursement will be reduced). If a PAP’s average costs are between these two levels, reimbursement levels will not be changed.

Ohio launched its EOC model in 2014 with the design of six Wave 1 episodes: asthma (acute exacerbation), perinatal, chronic obstructive pulmonary disease exacerbation, acute percutaneous coronary intervention (i.e., angioplasty), nonacute percutaneous coronary intervention, and joint replacement. To provide Medicaid and private providers and payers an opportunity to test the method, build provider awareness, conduct the data analyses necessary to set incentive payment thresholds, accustom providers to the concept of episodes, and test the data reporting, 2015 served as a reporting-only period for Wave 1 episodes. The performance period tied to Wave 1 episodes began on January 1, 2016, but incentive payments or withholds will not be administered until 2017.

The state developed the episodes and base definitions with input from clinical advisory groups, which consisted of clinical leaders from across the state. Over 100 clinicians participated in four working sessions for each episode, which reviewed prototype definitions and detailed claims-based analysis and provided clinical input into the definitions. All episodes are derived from a base definition, which includes a standard approach all payers should adopt—with some elements payers should “align [on] in principle” but need not be the same across payers, and some elements payers may choose to “differ by design.” Episodes are consistent across Medicaid managed care plans, but commercial payers may customize definitions based on their population and payment preferences.

Various stakeholders felt that EOCs is the correct path to take in moving towards a value-based payment model and are pleased with the overall design. Many stakeholders felt that an advantage to this approach is the ability for clinicians to see data depicting their performance. Two stakeholders particularly liked how this approach affects a wide spectrum of clinical care.

As of the site visit, quarterly data reports to PAPs had been distributed for both Wave 1 and Wave 2 episodes. McKinsey has been responsible for the production of these reports; but starting in 2017, Ohio will be shifting to another vendor. One state official described the shift in

the production of reports as part of the “knowledge transfer” to state officials that needs to take place for the quality of the reports to be sustained after the end of SIM funding.

Although performance reports have been distributed to stakeholders, they reported mixed opinions as to whether most providers know about the EOC initiative, understand EOCs, are taking the time to read the reports, and have the technical skills to understand them. None of the participants in the provider focus group in Cleveland, which consisted solely of likely PAPs for Wave 1 episodes, was aware of the EOC initiative. Some stakeholders representing payers and providers had not heard much from providers, leading these stakeholders to believe that, until providers are financially affected, they will not be much engaged.

Wave 2 episodes—upper respiratory infection, urinary tract infection, cholecystectomy, appendectomy, upper gastrointestinal endoscopy, colonoscopy, and gastrointestinal hemorrhage—began a year-long, reporting-only period on January 1, 2016. Although the state distributed informational reports to providers, the performance period was not scheduled to begin until January 1, 2017, with payments not distributed until 2018. Wave 3 episodes were still being finalized as of the 2016 site visit, but will include two to three behavioral health episodes. The state has depended heavily on McKinsey, for the extensive and sophisticated data development and analyses needed to operationalize the episodes.

Since receiving the SIM award, Ohio has reconsidered its original, measured pace of developing episodes, and now plans to develop and implement 50 episodes over the next 2 years. While stakeholders expressed mixed views of this rapid scale up, all agreed it will require a major effort by the state. State officials commented that Ohio will have to provide state funds for this accelerated scale up, because federal budgeting rules do not allow future-year funds to be accessed in advance of the project year. One stakeholder noted frustration surrounding the federal government’s lack of flexibility regarding funding.

H.3.5 Health information technology and data infrastructure

Health IT is not a formal component of the Ohio SIM Initiative, and the Office of Health Transformation staff tasked with the SIM Initiative have not focused on it. Nonetheless, EHRs can be an important component of both PCMHs and EOCs. One payer representative noted that EHRs are important mechanisms to address gaps in care coordination, especially for populations with chronic diseases. Data transfer among EHRs is particularly important, as patients receive medical care from different health care providers; respondents reported that the large, integrated health systems, such as the Cleveland Clinic, had EHRs that allowed physicians to communicate with one another, but only for those within the health system. Additionally, Ohio has two health information exchanges working to improve data sharing capabilities among payers and providers in the state. As with its other health reform initiatives, the state’s approach emphasizes voluntary action to encourage buy-in and collaboration, rather than mandate certain actions.

Consumer-focused health IT is also a component of health care delivery in Ohio, although not a direct part of the SIM Initiative. For health IT transformation, Ohio has prioritized increasing utilization of health IT to improve care coordination for patients (e.g., “My Chart,” a patient portal). Stakeholders expect these efforts to augment the SIM Initiative’s care coordination activities.

H.3.6 Workforce development

Ohio recognizes the importance of improving and scaling up the existing workforce through complementary initiatives. In 2013, the Office of Health Transformation adopted a comprehensive plan for Ohio’s health care workforce programs to support Advanced Primary Care and recruitment and retention of minorities in health care professions. The plan consisted of four different components: (1) assessing and identifying needs of primary care through reporting to the national Minimum Data Set, enhancing the Minimum Data Set to identify health profession shortages, and developing an advanced primary care workforce forecasting model; (2) retaining talent through target scholarships and loan repayment; (3) reforming training; and (4) aligning payment by coordinating workforce policy priorities with PCMH and EOC models. Many stakeholders were not aware of the work taking place, with one respondent commenting that “my lack of clarity probably matches yours.” Ohio recognizes the need to develop an education and outreach strategy for PCPs and other clinicians to assist them in meeting criteria to certify their practices as PCMHs. A plan to address these needs is being developed.

Ohio aims to refocus \$100 million in Medicaid direct graduate medical education funds to support health care workforce priorities and training in new models of care, including funding for 50 PCMH education pilot sites and 50 pediatric education pilot sites. One stakeholder described the Medicaid direct graduate medical education funding system as “antiquated,” with many stakeholders recognizing the importance of updating the current system. In October and November 2015, the Office of Health Transformation convened a study committee and invited public testimony on recommendations for updating the funding formula, creating a comprehensive approach to medical education, and promoting state priorities. The state submitted a report to the Ohio General Assembly and Governor on December 15, 2015, which included a proposal to change the formula. The Ohio Department of Medicaid originally planned to propose an Ohio Administrative Rule change by July 1, 2016, with adoption of the new formula on July 1, 2017. However, as of the site visit, the future of the formula remains unclear. As one state official commented, “We are still in the fight about the rebasing of the current formula” and another stakeholder thought a “new package” was not ready for implementation. While this process has been slower than initially expected, a state official felt the Ohio Department of Health is “bringing good ideas and moving forward” and “aligning with what the needs are in Ohio.”

H.3.7 Population health

The Ohio SIM Initiative's population health strategy focuses on alignment among the existing, population health, statewide and local initiatives, and between these initiatives and the SIM PCMH and EOC health care transformation initiatives. Specifically, the state hopes to incorporate common measures and establish common priorities for population health, across health care, public health, and community-based systems and initiatives. It also wants to coordinate the many health-planning activities that exist in Ohio at the state and local levels. Compared to some other states, Ohio has a very decentralized, public health system, with many planning activities taking place at the regional and local levels.

To kick off this strategy, the state contracted with the Health Policy Institute of Ohio to assist the state in identifying population health priority areas and how they could align with the PCMH model. The Health Policy Institute of Ohio also analyzed the population health planning infrastructure at state, regional and local levels, and made recommendations to improve the State Health Improvement Plan process, while aligning with local and hospital community benefit plans. In late 2015, the Institute convened six meetings of public and private agencies and stakeholders. Its January 2016 report contains recommendations to improve state level health improvement planning, align local priorities, and incorporate population health priorities into primary care.

In response to that report, state legislation (ORC 3701.981) has been enacted to align to the same 3-year timeframes for conducting assessments by community benefit hospitals (as required by the federal Internal Revenue Service), local health departments (a requirement for their accreditation, which is now required by state law), and the State Health Assessment. By 2020, all three will be on the same time schedule. The new state statute also requires that both local health department and community benefit hospital assessments and plans, along with Schedule H hospital expenditure information, be made public in a new repository.

The state subsequently contracted with the Health Policy Institute of Ohio to develop the statewide needs assessment and guidance for local assessments, which was due in July 2016. Their report identified the top 10 population health priorities for Ohio. The state shared the report with the SIM PCMH design team, which led to alignment in concept with some of the clinical metrics to be used to determine outcomes-based payments for PCMHs. Some interviewees noted that alignment with EOCs could also occur in the future (e.g., around infant mortality outcomes and perinatal episodes).

Stakeholders interviewed had varying degrees of familiarity and involvement with this population health work. Stakeholders engaged in the population health initiative praised the work of the Health Policy Institute of Ohio as being well organized, inclusive, informative, interesting, and productive. Many described the data the Institute assembled as a “real eye opener” in understanding how poorly the state has been doing on health outcomes.

Some stakeholders also talked about population health in terms of efforts under way by health plans, particularly Medicaid managed care plans, to address health through services that extend beyond the traditional boundaries of medical care. Examples include health plans addressing employment, housing, legal, and other nonmedical services. The health system culture that supported such ventures, while structurally independent of the SIM Initiative, has been helped by the SIM transformation activities, according to some stakeholders.

H.3.8 Technical assistance and other support resources

Several stakeholders noted that the state is moving very quickly and making good progress in SIM planning and implementation. Thus, state officials felt little need for the technical assistance CMS offered, in part because they believed that assistance to be too general. Additionally, senior state officials felt that Ohio's consultant, McKinsey, was effective in working through technical issues. However, several stakeholders commented that McKinsey is applying a model from another state (i.e., Arkansas) without adequately considering Ohio-specific differences.⁷⁰

While stakeholders generally noted a positive working relationship with CMMI, many interviewees expressed frustration with other components of CMS, and with their lack of internal coordination. In the case of the Centers for Medicaid and CHIP Services (CMCS), stakeholders understood the reasons for a different stance toward the states, but were still discouraged by the contrast in focus and methods of operation between CMCS and CMMI. While some observers saw the difference as an inherent structural problem, they also noted the difficulty for states of CMMI encouraging innovations and creativity, while CMCS maintained its focus on regulatory compliance and "checking the boxes."

Stakeholders also expressed the view that Medicare's lack of involvement with the SIM Initiative limited SIM's potential to transform the health care system, by excluding a critical payer that provided care for many high-cost Ohio residents. Most recently, the state was surprised by the announcement of CPC+ and the joint announcement of quality metrics by Medicare and private health insurers. State officials felt that Medicare knew the directions states were taking, and could have taken steps to inform their work and enable alignment before the fact. By the time CPC+ details were announced, Ohio already had done a lot of work on quality metrics for its SIM PCMH model. Fortunately for the state, while some changes were necessary to align with the CMS metrics, many of the measures are the same or close.

⁷⁰ OHT disputes this characterization stated that McKinsey did not make decisions on model design. Officials reported that the state's leadership determined the models elements and requirements.

H.3.9 Progress, challenges, and lessons

The most important achievements of the SIM Initiative, according to stakeholders, are that the state has chosen its path to health care transformation, mostly developed detailed requirements for its EOC and PCMH models, and begun SIM implementation.

A recurring theme regarding the success of the Ohio SIM Initiative is the state's ability to convene and align a large, diverse, and competing group of stakeholders. Stakeholders representing payers, providers, and state officials all reflected that creation of the Office of Health Transformation has been a considerable asset to the state's efforts to reform their health care system. One payer noted, "The fact that we had this group created by the Governor's mandate, given the diversity of payers and providers, has been instrumental." Stakeholders also described leadership by the Medicaid agency and its ability to set goals and metrics to encourage payers and providers as a positive influence on delivery system reform. Stakeholders offered little negative feedback on the effort the state has put forth or the specific approaches it has taken towards transformation.

Another success has been the population health initiatives that Ohio has linked to the SIM Initiative—with many stakeholders praising the Health Policy Institute of Ohio's efforts in engaging a diverse range of stakeholders in assessing and advising on the work. One payer noted, "They did an outstanding job It was exhausting to participate because of so much discussion but really interesting and illuminating. We heard from local providers, county boards of health, smoking cessation advocates, etc. They had such a wealth of input and they steered the discussion well ... but roped it in to the point where there was actually movement on the issues." Population health priorities this process identified have been aligned with clinical quality measures for the PCMH model. Additionally, legislation has already been enacted to align state, local, and hospital assessment cycles and to publicly share assessments and plans.

Interviewees cited a number of challenges. Although Ohio has engaged Medicaid managed care and major commercial health plans, key providers, and consumer advocacy groups, many stakeholders thought more could be done to keep them informed as implementation progresses, and fully integrate provider and consumer feedback and participation in the SIM Initiative. That Ohio's SIM Initiative involves technically complex transformations not easily communicated to community stakeholders was apparent in interviews and focus groups with providers, community members, and consumer agencies. Consumer advocates, who expressed limited knowledge about the SIM Initiative, felt particularly "out of the loop" in the implementation stage. One consumer advocate reflected that they "felt their voice was heard" in the initial consumer and patient focus groups and PCMH design team. However, the consumer advocate said that they did not feel that the voice of the consumer-patient was present at other levels of the SIM design and process (e.g., the EOC Design, SIM Core, SIM Governance teams).

Challenges related to Ohio's health care system also were identified by stakeholders. General concern was expressed about the impact of the SIM Initiative on rural and small practices. While there seemed to be universal agreement that Ohio's health care system needs to move to a focus on value, stakeholders expressed uncertainty, and in some cases skepticism, about the SIM Initiative's overall impact on health outcomes and cost.

Another challenge noted was the need to keep to the more rapid schedule to which Ohio is now committed. Ohio has opted to accelerate implementation of both its PCMH and EOC models, due in part to careful planning and design by stakeholders and contractors prior to the SIM award. Through the leadership of the Office of Health Transformation, and building on its work, Ohio's participation in the SIM Initiative gave the state the opportunity to lay a solid foundation and create a roadmap for successful implementation of its health care system reform initiatives.

State officials noted that Ohio has already developed 13 EOCs, so is well on its way to constructing the targeted 50 EOCs. These officials also said that contracting with McKinsey has been a significant part of Ohio's ability to accelerate the PCMH and EOC models, as the firm has already implemented these models in other states. A challenge for Ohio, though, is continuing to ensure buy-in and support from stakeholders who question the application of the EOC model McKinsey has used in other states. Moving forward, Ohio also will have to grapple with the highly technical complexities of this model and its implementation.

H.4 Statewide Changes

At the time of the 2016 site visit, Ohio had not yet implemented its SIM Initiative, and data were not available to evaluate any changes in outcomes. This section relays what stakeholders identified as the expected outcomes of the SIM Initiative. Even with that caveat, at the time of the 2016 site visit, stakeholders (including state officials) were very focused on implementing the SIM Initiative and were not giving sustained attention to what their effects were likely to be. However, stakeholders generally expected the changes to reduce the rate of increase in health care expenditures, lessen unnecessary utilization, and improve quality of care.

H.4.1 Health care expenditures

The Ohio SIM Initiative aims to control health care expenditures, while increasing health care quality. Payers and providers in Ohio reported the need to increase health care value in the state, because dollars spent do not always align with quality of care. Stakeholders expressed hope that the SIM Initiative will positively affect cost and quality. Stakeholders also noted that Ohio is in the early stages of transitioning from a FFS payment system, in part due to the SIM Initiative. Some providers were skeptical that the SIM Initiative will bend the cost curve—particularly pediatricians, who noted that pediatric health care is mostly preventive, which will not affect health costs or savings for many years into the future. Even though the effects may not be seen

immediately, however, providers were optimistic that the state is moving in the right direction by raising awareness about health care value and preventive services.

H.4.2 Health care utilization

Health care utilization and costs are closely linked, and both PCMHs and EOCs are designed to reduce unnecessary care, especially by specialists. Two stakeholders felt there has already been some improvement, particularly around efficiency metrics related to cost and utilization, even though the interventions have not yet been implemented. According to one stakeholder, holding the discussions and making the data available have had positive effects. Stakeholders were optimistic about the SIM Initiative being able to influence utilization. Ohio plans to track and assess utilization performance metrics pertaining to hospital readmission rates and ER visits for patients participating in PCMHs.

Provider and consumer focus group participants in Cleveland presented differing perspectives regarding some of the initiatives to improve patient access and control. While not a SIM Initiative, most focus group consumers said they had heard of or are using “My Chart,” a patient portal, and characterized it as a helpful feature allowing them to communicate with their provider outside the provider’s office or clinic. In contrast, providers felt that patients being able to communicate with them electronically at any time of the day and night is a problem—using such words as “fatigued,” “overwhelmed,” and “struggling” to describe their experience with these new, consumer-enabling technologies.

H.4.3 Care coordination

Care coordination is central to the Ohio SIM Initiative; both PCMHs and EOCs posit that improving communication and integration of care will improve patient health, decrease unnecessary utilization, and reduce expenditures. Although the state envisions Medicaid and private insurers providing funds for care coordination in PCMHs, the state does not intend to mandate that PCMHs hire care coordinators to participate. Nonetheless, some providers reported that they have already done so, and that the care coordinators are focusing on the needs of complex and expensive patients. Other stakeholders expressed skepticism about whether care coordinators will be able to substantially affect expenditures, utilization, or quality of care. This skepticism was mostly due to what they perceived as the high, front-end costs of establishing care coordination services—including things like changing physician workflows, hiring care coordination staff, and increasing documentation.

One state official described the coordination between Medicaid and Medicare as “two ships passing in the night,” and suggested that Ohio has a lot of room for improving care coordination for Medicare-Medicaid beneficiaries. Payers also suggested that Ohio has a large range of providers and payers operating in their health care system and that this leads to care coordination challenges within the state. Stakeholders particularly saw room for care

coordination improvements around ER utilization. State officials and other payers expressed the belief that the PCMH model holds promise for improving care coordination in Ohio.

H.4.4 Quality of care

As in most states, quality of care varies in Ohio. On the one hand, there are nationally and internationally known health care providers, such as the Cleveland Clinic, University Hospitals of Cleveland (the network of hospitals affiliated with Case Western Reserve University), and Ohio State University Wexner Medical Center. At the same time, the number of small practices is dwindling, especially in the more rural parts of the state that are less connected to the latest medical advances. While stakeholders thought that quality of care could be improved, none described quality as bad overall. Indeed, Medicaid consumers in the Cleveland focus group were generally, although not universally, positive about the quality of care they receive.

Stakeholders said they expect that developing quality metrics and financially incentivizing providers through the PCMH and EOC initiatives will improve quality. In addition, some stakeholders expressed positive expectations that tying quality measures to priority population health outcomes can have an additional impact, by further focusing attention on those measures.

H.4.5 Population health

To Ohio stakeholders, success in terms of population health would involve agreement across health system stakeholders around key health priorities; be translated into shared metrics; be supported and rewarded with resources to invest in the priorities; and ultimately result in improved outcomes in priority areas. While there was almost universal positive feedback about the process and outcome of the Health Policy Institute of Ohio's work on population health, there were more mixed perspectives and less certainty about the future population health impact of this and subsequent related work. Several stakeholders were positive, even excited, about the contribution of the population health focus to changing the culture, informing health care system players about health outcomes in the state, and bringing diverse stakeholders together around the concept, as well as about the intent to align the population health and health care initiatives to have an impact on Ohio health outcomes.

On the other hand, some stakeholders expressed uncertainty and skepticism about whether the SIM Initiative will have an impact on practice and on resources targeted to population health. One stakeholder described the work on population health as "theoretical," and said that it is not apparent how the work of alignment around goals will happen at the community level. Others spoke of the challenges of operationalizing the work around common population and clinical measures, with the technicalities of aligning definitions and dealing with differing data sources hard and frustrating for consumer advocates to understand. Still others noted that a large, culture shift will be necessary for physicians and hospitals to take a broader view of health, beyond the services they provide. Stakeholders also expressed concern about whether these

changes can be accomplished without additional resources—and whether those will be forthcoming, because the current state administration has no plans to increase funding for public health programs at the state, regional, or local levels.

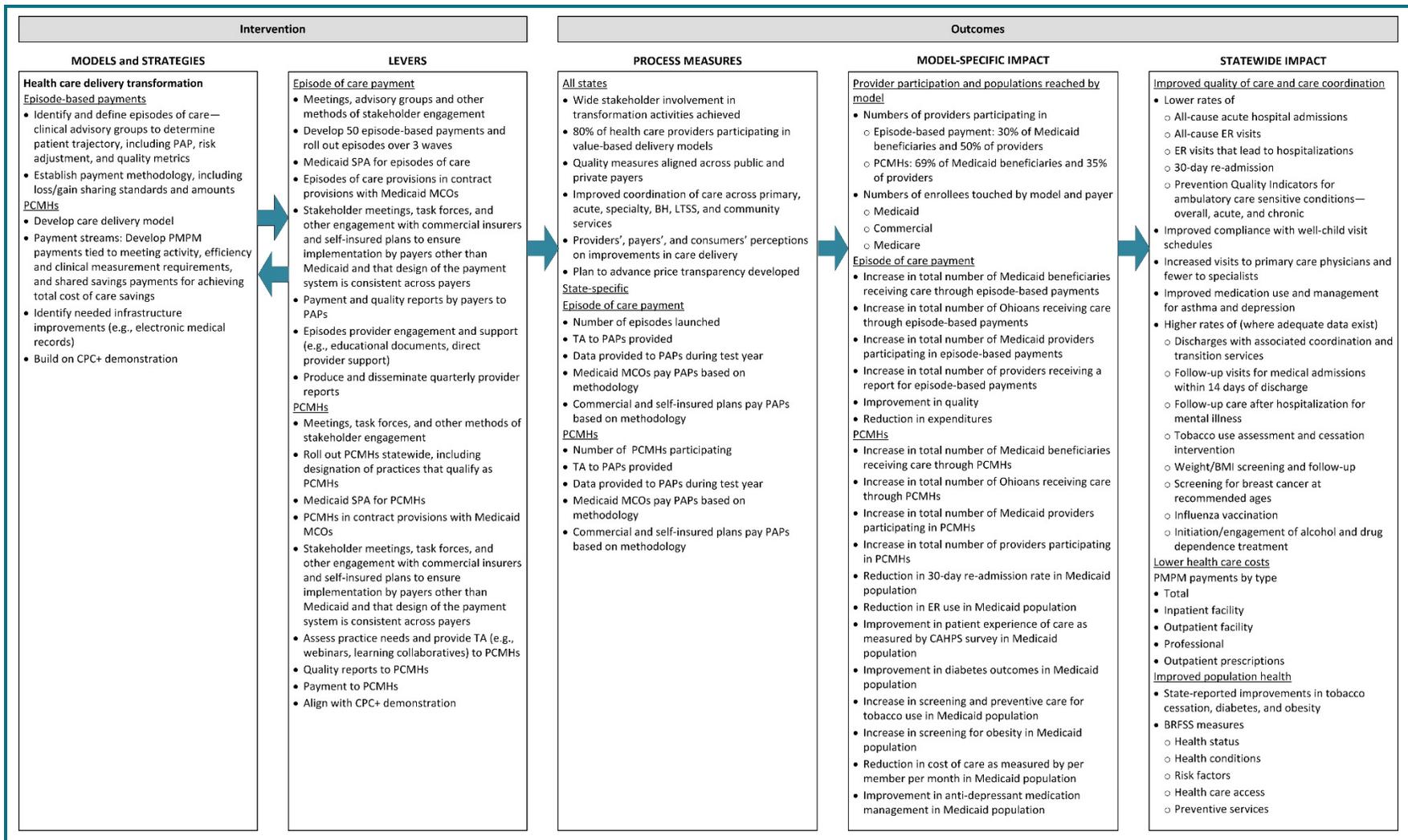
H.5 Overall Ohio Summary

As of the June 2016 site visit, Ohio had not yet fully implemented its SIM Initiative activities, so data are not available to evaluate any changes in outcomes. Stakeholders, including state officials, were very focused on SIM implementation and not concentrating on what the effects of the changes are likely to be. Nevertheless, there was a sense of excitement and enthusiasm across stakeholders, particularly payers and state officials, regarding the potential impact of the SIM Initiative. One payer commented, “I love it, it is exciting to see that we all agree where we need to go.”

As the Ohio SIM Initiative is implemented, certain features will be important to monitor. Since launching the SIM Initiative, for example, Ohio has made changes to its PCMH requirements to better align with CPC+. How these two models will work together and the potential impact were unclear at the time of the site visit, but will be important to watch in the year following the June 2016 site visit. Ohio’s decision to implement the PCMH model statewide, rather than on a phased, regional basis, should increase its impact on state-level metrics. According to one stakeholder, previous PCMHs in the state have made little impact. Ohio hopes the statewide roll-out will accelerate the timing of measurable SIM effects.

It also will be important to monitor Ohio’s progress in developing and implementing 50 episodes over the next 2 years, as this is a large increase in the number of episodes compared to the original plans. Beginning in 2017, incentive payments and withholds will be administered for Wave 1 EOCs. Although payers had not heard much from providers about the episode data reports at the time of the site visit, and felt physicians were not taking the time to open reports and understand their performance, payers said they anticipate that the payments and withholds will “get their attention.”

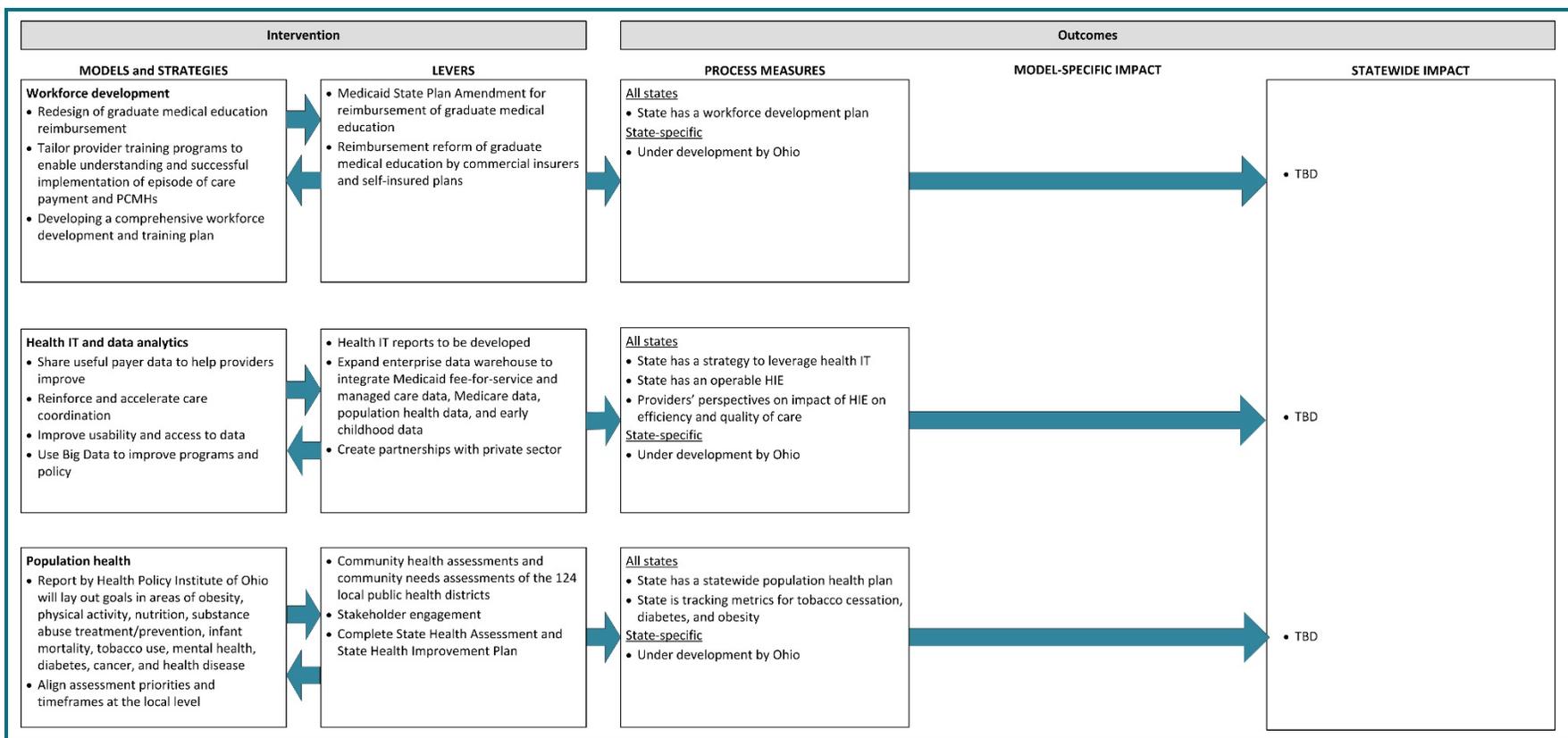
Figure H-1. Logic model for Ohio’s State Innovation Model activities



(continued)

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Figure H-1. Logic model for Ohio's State Innovation Model activities (continued)



H-23

BH = behavioral health; BMI = body mass index; BRFS = Behavioral Risk Factor Surveillance System; CAHPS = Consumer Assessment of Healthcare Providers and Systems; CPC+ = Comprehensive Primary Care Plus; ER = emergency room; health IT = health information technology; HIE = health information exchange; LTSS = long-term services and supports; MCO = managed care organization; PAP = principal accountable provider; PCMH = patient-centered medical home; PMPM = per member per month; SIM = State Innovation Model; SPA = state plan amendment; TA = technical assistance; TBD = to be determined.

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Appendix I: Rhode Island Site Visit Report

The RTI team conducted a site visit in Rhode Island on May 23–25, 2016, approximately 1 month prior to the state’s July 1, 2016, SIM implementation date. Eighteen in-person interviews were conducted in and around Providence and Cranston, while four phone interviews took place in the week following the site visit. State officials, payers, primary care and behavioral health providers, and consumer advocates were represented in these interviews. Four focus groups were conducted in Providence—two with Medicaid beneficiaries who had behavioral health conditions (some of whom also had concurrent acute and/or chronic illnesses); and two with behavioral health providers (including social workers, substance abuse counselors, and child psychiatrists).

This appendix provides an overview of the Rhode Island SIM Initiative. It describes the current health care context in Rhode Island in which the SIM Initiative is being implemented and summarizes its chief components—including planned innovations, as well as governance structure and function. The appendix also outlines early implementation successes, challenges, and lessons learned; and provides key findings from the interviews and focus groups. This appendix includes findings based on qualitative data collected through June 30, 2016. Further details on the analytic approach are available in *Appendix L*. Information on the site visit interviewees for the state is in *Table L-1*, and information on the provider and consumer focus group participants for the state is in *Tables L-4* and *L-5*, respectively.

I.1 Overview of Rhode Island’s State Innovation Model

The SIM Initiative aims to improve population health and accelerate statewide delivery system transformation by making significant investments in (1) enhancing the capacity of the health care workforce to better treat patients with complex conditions and (2) strengthening care coordination through increased use of data and health information technology (health IT). The cornerstone of the state’s SIM Initiative is physical and behavioral health integration, which the state believes is essential to improving the quality of care for Rhode Island residents and reducing health care costs. The state also intends to leverage its SIM Model Test award to help facilitate alignment and integration across multiple health care innovation activities operating in the state.

Rhode Island has identified the following three aims for its SIM Initiative: (1) reduce the rate of increase in health care spending, (2) support provider practice transformation, and (3) empower patients to become better patient advocates (patient engagement). The state has established an overarching goal of having 50 percent of commercial and Medicaid reimbursements paid under an alternative payment model (APM) by 2018, and 80 percent of reimbursements linked to value. To reduce health care spending, Rhode Island is targeting its SIM resources largely toward financing development of new community health teams (CHTs), creating an integrated, quality reporting and measurement system, and enhancing the state’s data

infrastructure and analytic capacity. The state’s practice transformation investments consist of expanding the state’s patient-centered medical home (PCMH) model to children, and delivering additional training and support to primary care and behavioral health providers on care integration strategies. Lastly, Rhode Island plans to empower patients by creating and implementing a slate of patient engagement tools to help patients more effectively engage in their own health care. In Year 1, the state articulated specific strategies and activities related to its spending reduction and practice transformation aims, but had not clearly defined its approach to patient engagement by the time of the 2016 site visit.

I.2 Logic Model

Figure I-1, located at the end of this appendix, depicts a logic model of the Rhode Island SIM Initiative. This model describes each of the state’s SIM interventions, any relevant policy levers employed by the state, preliminary measures selected to assess impact, and SIM interventions’ hypothesized impact on quality, cost, and health.

Column 1 describes the state’s interventions across four key domains—health care delivery transformation, workforce development, health IT, and population health. The state’s primary health care delivery activities involve expanding its PCMH model to kids and furthering the integration of behavioral health with primary care. Column 2 displays the state’s regulatory and purchasing authority the SIM Initiative plans to invoke to facilitate health care delivery transformation.

Column 3 outlines state-specific process measures for developing the workforce and building the health IT infrastructure. To prepare the state’s health care workforce to function effectively in new delivery models, the state plans to train primary care physicians and behavioral health practitioners on integration approaches and screening tools to better identify and detect mental illness and substance abuse. Column 3 also displays the state’s planned health IT activities: enhancing the state’s all-payer claims database (APCD), implementing a statewide provider directory, creating a data ecosystem, and developing a unified quality measurement and reporting system. Column 4 includes the intended model-specific impact outcomes related to bolstering the workforce: enhanced quality of care and better care coordination for patients with mental illness and substance use disorders. Column 5 describes statewide impact outcomes, which are to help improve the quality of care delivered to beneficiaries, enhance care coordination, and reduce health care costs and utilization of unnecessary services. The state has not yet defined specific activities in population health as of the time of this report, but is considering directing resources toward tobacco use, obesity, chronic disease, and behavioral health morbidity.

I.3 Implementation Activities

I.3.1 Context of health care system

For many years prior to the Affordable Care Act (ACA), Rhode Island policy makers had been pursuing activities to spur health care reform and move public and private payers towards a more value-based reimbursement framework. The SIM Initiative seeks to build on this work by expanding current delivery reform approaches designed to transform primary care (specifically its long-standing PCMH program and CHT initiative), as well as improve the quality of care delivered to individuals with mental health and substance use disorders. In addition to investing in training its existing health care workforce on behavioral health integration models, the state intends to bolster its SIM activities by enhancing its already robust health IT infrastructure and data analytic capacity.

In 2008, the state implemented one of the first multi-payer PCMH initiatives in the country, the Chronic Care Sustainability Initiative—now titled the Care Transformation Collaborative of Rhode Island (CTC-RI). One of its key objectives was to transition the state’s current health care delivery system, based largely on fee-for-service (FFS) reimbursement, to a more value-driven and patient-centered system.⁷¹ As of spring 2016, the state’s PCMH initiative includes 73 practice sites and 430 primary care providers (PCPs), and serves over 300,000 patients, mostly adults.⁷² The SIM Initiative is using its funding, as noted, to expand its PCMH model to the pediatric population (titled PCMH Kids).

Rhode Island is unique in that it has an Office of the Health Insurance Commissioner (OHIC). Created in 2004, this state agency plays an influential role in guiding and influencing the behavior of commercial health insurance plans through regulation. Since its inception, OHIC has instituted and refined a set of affordability standards—designed to expand adoption of PCMHs among private payers, increase implementation of value-based purchasing mechanisms, and reduce health care spending in the state. To advance PCMH adoption, OHIC requires private health plans to expand the percentage of primary care networks participating in a PCMH to 80 percent by 2019.⁷³ In February 2015, OHIC promulgated regulations that required commercial

⁷¹ State of Rhode Island, Office of the Health Insurance Commissioner. (2015, July). *Rhode Island 2016 Care Transformation Plan*. Retrieved September 7, 2016, from <http://www.ohic.ri.gov/documents/Rhode-Island-2016-Care-Transformation-Plan.pdf>.

⁷² Care Transformation Collaborative of Rhode Island. (2014). *Care Transformation Collaborative Annual Report 2014*. Retrieved July 18, 2017, from <https://www.ctc-ri.org/sites/default/files/uploads/documents/annual-reports/CTC%202014%20Annual%20Report%20FINAL.pdf>

⁷³ State of Rhode Island, Executive Office of Health & Human Services. (2016, May). *Rhode Island State Innovation Model (SIM) test grant: Operational plan, Version 2*. Cranston, RI: Executive Office of Health & Human Services.

insurers to “significantly reduce the use of fee-for-service payment” and developed targets for adoption of APMs for years 2016 through 2018.⁷⁴

Other policymaking activities have continued to foster multi-payer delivery system transformation across the state. Shortly after ACA passage, the former Governor created the Rhode Island Health Care Reform Commission, which recommended strengthening the state’s primary care infrastructure and experimenting with new payment models to boost quality and reduce costs. Additionally, in 2015, the Governor signed an executive order that created a Working Group to Reinvent Medicaid, which outlined an approach to improve the value and quality of health care delivered in the Medicaid program. Medicaid has adopted the same APM targets for its participating Medicaid managed care organizations (MCOs) as those required for commercial health plans. To help catalyze APM adoption in Medicaid, the state initiated the Medicaid Accountable Entities Pilot at the start of 2016, which enables qualified provider organizations to contract with Medicaid MCOs on a total-cost-of-care basis, and thus integrate behavioral and physical health.

An additional strength of the Rhode Island health care system is its strong health IT infrastructure, as noted, which includes an APCD and a statewide health information exchange (HIE). Rhode Island has also invested in a patient dashboard and a planning effort for a statewide provider directory, which also preceded the SIM Initiative. Despite Rhode Island’s strong health IT system, stakeholders reported some gaps in health IT, data analytics, and workforce supports. These gaps, including the absence of an overarching strategic health IT plan, prevent the state from achieving the Rhode Island vision.

Medicaid Managed Care and Commercial Markets in Rhode Island

Rhode Island has a substantial and long-standing Medicaid managed care program. This was established in 1994 and first served primarily low-income children and families. Since 1994, the program has expanded to include children with special health care needs, people with disabilities, and the ACA’s Medicaid expansion population, among others. As of March 2016, almost 231,300 Medicaid beneficiaries were receiving services from one of two contracted MCOs.⁷⁵ In July 2016, Medicaid began a new Medicaid managed care procurement process. The Medicaid Managed Care Services request for proposals (RFPs) and model contract operationalize several SIM objectives.⁷⁶ Among other things, they establish expectations for MCOs’ use of APMs and targets for PCMH availability to Medicaid members, including

⁷⁴ Regulatory targets for APM adoption by commercial health plans are as follows: 30 percent in 2016, 40 percent in 2017, and 50 percent in 2018. Extracted from Rhode Island SIM Operational Plan, May 2016.

⁷⁵ State of Rhode Island. (2016, July 14). *Solicitation information, July 14, 2016: LOI#7550787, TITLE: Medicaid Managed Care Services*. Retrieved September 8, 2016, from <http://www.purchasing.ri.gov/RIVIP/StateAgencyBids/7550787.pdf>.

⁷⁶Ibid.

children.⁷⁷ The RFP also explicitly states that selected MCOs will be expected to be “engaged and positive participants” in the SIM Initiative.

The commercial health insurance market in Rhode Island consists of four major carriers: Blue Cross Blue Shield of Rhode Island (BCBSRI), Neighborhood Health Plan of Rhode Island, Tufts Health Plan, and United Healthcare. BCBSRI has the largest market share in the small, large, and individual markets. As of 2013, 77 percent of private sector employers in Rhode Island offering health insurance coverage offered some type of managed care plan.⁷⁸ Shortly after ACA passage, OHIC developed the set of affordability standards described above. The insurance commissioner has expanded upon these standards since their initial implementation in 2010, by setting targets for both PCMH and APM adoption. As of 2014, 24 percent of commercial payments were made under an APM. As of 2016, the state requires insurers to increase the percentage of their primary care network functioning as a PCMH by five percentage points, and has established a target of 30 percent of commercially insured medical payments to be made under an APM.⁷⁹ In an effort to coordinate payment reform activities across all payers, the targets and standards are aligned across Medicaid MCOs and commercial health plans.

Need for Behavioral Health Integration

According to a report prepared for the state by Truven Health Analytics, several factors suggest a need for improving access to behavioral health care in Rhode Island, including an elevated prevalence of some behavioral health disorders and recent decreases in funding for treatment.⁸⁰ Compared to children in other New England states and the nation, children in Rhode Island face greater economic, social, and familial risks for development of behavioral health disorders. Additionally, children and adolescents in the state have rates of depression, attention deficit hyperactivity disorder diagnosis, and marijuana and other illicit drug use that exceed the national average.

The Truven Health Analytics report further described the behavioral health needs for adults in Rhode Island. The rates of adults diagnosed with a serious mental illness (SMI) and adults reporting a major depressive episode in the state exceeded national averages in 2012–2013. Depression ranked as the third most highly reported common chronic condition in the state in 2014, below hypertension and diabetes; and more than one in five adults aged 18–24 reported substance use dependence in 2008–2013.

⁷⁷ Model Contract for 2016 Procurement.

⁷⁸ State Health Access Data Assistance Center (SHADAC). (2015, April). *Rhode Island state profile*. Retrieved from <http://www.shadac.org/state/ri>.

⁷⁹ State of Rhode Island, Office of the Health Insurance Commissioner. (2015, July 28). *Press release: OHIC adopts standards to improve health care delivery and payment systems*. Retrieved September 8, 2016, from <http://www.ohic.ri.gov/documents/Press-OHIC-Adopts-Standards-Improve-HCPDS.pdf>.

⁸⁰ Truven Health Analytics. (2015, September 15). *Rhode Island Behavioral Health Project: Final report*. Retrieved September 8, 2016, from <http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Truven%20Rhode%20Island%20Behavioral%20Health%20Final%20Report%209%2015%202015.pdf>.

While Rhode Island spends more on direct and indirect behavioral health care compared to other states, public financing for behavioral health has declined over the past few years. State funding for behavioral health care for children and adults decreased almost 37 percent (from \$60 million to \$38 million) between 2007 and 2014. State funding for services for substance use disorders was reduced from \$15.5 million to \$5 million over the same period.

To improve the quality of care delivered to patients with behavioral health conditions, the Rhode Island SIM Initiative plans to deliver training and coaching to primary care and behavioral health providers on care integration strategies. SIM resources will also be used to train providers in implementing a screening tool to better detect substance use disorders and risk and to create regional mental health consultation teams to assist pediatricians and primary care physicians in locating appropriate behavioral health services for children (discussed in more detail in topic-specific sections below).

Patients with behavioral health conditions participating in focus groups had mixed perceptions about how well coordinated care was between their behavioral health provider and their primary care provider (PCP). About half reported having a PCP who was aware of the type of behavioral health care they were receiving, including visits to their behavioral health provider and any medications they were taking. Other patients, even those who were receiving care from health care providers which co-located PCPs and behavioral health practitioners on site, reported that often PCPs were not aware of the care they were receiving from their behavioral health provider. These patients also reported feeling that their PCPs could be dismissive of their needs, were not very accessible, and at times did not respond to messages or phone calls.⁸¹

I.3.2 Governance and program administration

Rhode Island views its SIM Initiative as a partnership that depends on coordinated action by multiple state agencies. Their governance structure is designed to support this vision.

The SIM Steering Committee, which includes both public and private sector members, provides direction to the SIM Initiative, which OHIC administers. Rhode Island has used its SIM award to fund seven staff—three in OHIC (including the SIM Project Director), and the remaining four embedded in four other agencies with responsibility for implementing one or more components of this state’s SIM Initiative. Day-to-day responsibility for managing and coordinating SIM activities rests with these seven staff, which together constitute to SIM Core Team (see *Table I-1*). The Interagency Planning Team, which includes the leadership of these five agencies, among others, provides strategic oversight of the work. Although the SIM Project Director is positioned in OHIC, she reports to both the Rhode Island Health Insurance Commissioner and the secretary of the Executive Office of Health and Human Services (EOHHS). The SIM Core Team meets weekly to discuss SIM progress and challenges.

⁸¹ Findings from focus groups with patients with a behavioral health diagnosis. Conducted on May 26 and May 27, 2016, in Providence, RI.

Table I-1. State Innovation Model Core Team agencies and staff

Agency	Agency duties	SIM Core Team staff
OHIC	Oversees insurance, including setting quality and alternative payment targets for carriers.	Project director, 2 principal policy associates
RIDOH	Oversees creation of the Integrated Population Health Plan, assists with evaluation, and Community Health Teams Project.	Chief health program evaluator
BHDDH	Oversees behavioral health integration and behavioral health transformation efforts.	Program manager
EOHHS	Is umbrella agency for department of Health, BHDDH, DHS, and DCYF. Oversees Medicaid and health IT efforts, alignment with Governor’s Office initiatives.	Health IT specialist (An EOHHS expert on workforce issues also participates in SIM activities but is not supported with SIM funds.)
HealthSource RI	Is Rhode Island’s Health Insurance Marketplace, SIM responsibilities include development of consumer engagement tools.	Value-based purchasing analyst

BHDDH = Department of Behavioral Health, Developmental Disabilities and Hospitals; DCYF = Department of Children, Youth and Families; DHS = Department of Human Services; EOHHS = Executive Office of Health and Human Services; health IT = health information technology; OHIC = Office of the Health Insurance Commissioner; RIDOH = Rhode Island Department of Health; SIM = State Innovation Model.

Many interviewees noted that the hiring of dedicated staff for the SIM Initiative—particularly the Project Director—has been important to the state’s SIM progress. Several interviewees noted that hiring dedicated project staff accelerated the state’s progress on SIM activities. State officials noted that the matrix staffing model is helping to develop stronger interagency ties. One senior state official noted that, “It’s building relationships that will be valuable in a variety of ways and [has] given each of the agencies the opportunity to hire someone who’s specifically focused on transformation. They almost never get that opportunity. It’s been very positive.” The SIM Core Team is also supplemented by a project management vendor, the University of Massachusetts Medical School, which subcontracts with the Technical Assistance Collaborative and Providence Plan for assistance in planning behavioral health and physical health SIM activities.

The Interagency Planning Team also meets weekly. This group conducts strategic oversight, provides financial oversight and planning, organizes SIM goals and deliverables, oversees stakeholder engagement, and tracks metrics. The team includes leaders from each of the SIM-involved agencies and the health plan executive, who co-chairs the steering committee. The team also includes the Department of Children, Youth, and Families, which is responsible for child welfare and foster care programs—both of which are affected by the SIM Initiative activities, including behavioral health supports and PCMH Kids.

The SIM Steering Committee meets monthly and sets the direction for SIM Initiative activities, decides on priorities and strategies, and ratifies the project budget. The steering committee is co-chaired by the state Health Insurance Commissioner and the president and chief executive officer of a hospital health system. The steering committee is made up of 30 stakeholders representing state agencies, health care providers, commercial payers and purchasers, hospitals and medical associations, community-based and long-term services and supports providers, and consumer advocacy organizations—each of whom has committed to serving on the steering committee for the entire SIM test period. The steering committee uses a modified consensus model to reach decisions, as described further in *Stakeholder Participation, Section I.3.3*.

The steering committee has formed four work groups to support its efforts. Each is staffed by SIM Core Team members and stakeholders with relevant expertise. These work groups provide additional opportunities for stakeholder input and develop recommendations for consideration by the Steering Committee. These work groups include:

1. A work group to provide input on the state’s Integrated Population Health Plan (described in *Section I.3.7*)
2. A Measure Alignment work group that provides input on selection and harmonization of performance measures across commercial and public payers
3. A Patient Engagement work group that surveys current patient engagement activities in Rhode Island and provides recommendations for filling these gaps
4. A Technology Reporting work group that provides recommendations on creation and implementation of Rhode Island’s Quality, Measurement Reporting, and Feedback System (see *Section I.3.5*) and other health IT activities.

In addition to the four work groups formed by the SIM Steering Committee, SIM leadership obtains input from two groups formed before the SIM Initiative began: (1) the CHT group convened by EOHHS and CTC-RI, and (2) a Provider Practice Transformation group convened by CTC-RI, Healthcentric Advisors, and the Rhode Island Quality Institute. The CHT group informs SIM activities related to CHTs; the Provider Practice Transformation group informs SIM activities related to provider coaching, PCMH Kids, and behavioral health transformation. Members of the SIM Core Team participate in these two groups and serve as the conduit between these groups and the SIM Initiative. State officials noted that they prefer to use these existing groups rather than duplicate efforts by creating new groups with similar foci.

Many providers, payers, and consumer advocates said they are thankful to have been able to provide input into development of the SIM Operational Plan and feel some ownership over the project. One payer said that the state “take[s] our feedback and concerns seriously, and that’s important to all of the stakeholders.” Another interviewee noted that stakeholder comments provided during a steering committee meeting were incorporated into revisions of the SIM

Operational Plan. Members of the SIM Core Team emphasized the importance of appointing both a state official and a private sector leader to co-chair the steering committee, demonstrate that they view the SIM Initiative as a partnership, and operationalize that partnership. These interviewees reported that having a private sector co-chair facilitates community partnership and ensures SIM activities responded to community priorities. Additionally, the SIM Core team noted the co-chair's important, ongoing contributions to the SIM Initiative. For example, the co-chair advocated for the SIM Initiative to obtain input from local-level partners across the state on the Integrated Population Health Plan, to ensure alignment with other population health commitments like health equity zones and community health assessments.

A few interviewees held dissenting opinions regarding the extent to which the SIM Core Team incorporates feedback from stakeholders. A small number of the aforementioned interviewees expressed the opinion of the state as having pre-determined priorities, with one interviewee stating a belief that the state used “the process to justify what was already the plan.” Two interviewees noted that the short timeframes for the SIM Core Team to make decisions and return deliverables to CMS sometimes limited the extent to which committee members could provide input into SIM activities.

With respect to project funding, the general interviewee consensus was that the state is managing its SIM resources well, although many cited as a major challenge the reduction in the SIM Initiative budget from the state's initial application of \$60 million to the award amount of \$20 million. A senior state official said, “I think that if we had gotten more money, even another \$10 million, we would have set real examples for the rest of the country.” One steering committee member noted, “\$20 million sounds like a lot of money but thinking about what we've assigned that money to already, I do have concerns that we will not be able to do all that we want to do or planned to do with population health ...” Although many stakeholders could not point to specific activities dropped from the original Operational Plan—most of the initially proposed activities are still present, although reduced in scope—some cited patient engagement as an area that the reduced award did impact. One state official reported that a patient portal and electronic health record (EHR) incentive program for behavioral health and long-term care community providers was removed. Other stakeholders reported that some of the child health initiatives (such as PCMH Kids and the Child Psychiatry Access Program) were scaled back. The state has made efforts to prioritize SIM activities through consultation with the steering committee and through leveraging additional funding streams—such as a federal Substance Abuse and Mental Health Services Administration (SAMHSA) grant to support the SIM-related Screening, Brief Intervention, and Referral to Treatment (SBIRT) project.

I.3.3 Stakeholder participation

Rhode Island has a long history of strong stakeholder engagement and community-led decision-making. This commitment has been reflected throughout the state's SIM implementation, beginning with the SIM Model Design award and development of the Rhode

Island State Healthcare *Innovation Plan: Better Health, Better Care, Lower Cost*.⁸² The EOHHS Secretary, who was Rhode Island’s Lieutenant Governor during SIM planning, invited many stakeholder groups and work groups to participate in the Model Design plan. This commitment to stakeholder input continues, as many of these groups were also chosen to serve on the SIM Steering Committee.

The 30 steering committee members represent a variety of stakeholder types—including public and private organizations, health systems, state health and children’s agencies, consumer advocacy organizations, health plans, provider membership organizations, and behavioral health providers. The SIM Core Team, with guidance from the Interagency Planning Team, determines the agendas for the steering committee each month. The steering committee then makes decisions through a modified consensus process. At the point of decision-making, Committee members indicate “thumbs up” for agreement; “thumbs to the side” when a Committee member is not in complete agreement, but his/her reservations are not so severe that s/he will stand in the way of the decision; or “thumbs down” for severe objections. State officials indicated they have used this process to successfully address concerns of Committee members and there have been no issues, to date, on which the Committee could not reach consensus.

All steering committee meetings are open to the public, documents from these meetings are posted on the EOHHS website⁸³ and each meeting reserves time for comments from the public. State officials indicated that the number and types of individuals who attend steering committee meetings varies, depending on the agenda topics, but that some meetings have attracted as many as 60 participants. Most interviewees said the appropriate stakeholders have been engaged in the steering committee and work group process—although a few noted that legislators and consumers directly affected by the SIM Initiative have played a limited role in SIM planning and implementation. One interviewee said that legislators have played a limited role in the SIM Initiative. However, the SIM Core team clarified that the Governor’s office, which is represented on the steering committee, is responsible for the relationship with the legislature.

Although stakeholders are proud of the state’s stakeholder-led and consensus-driven decision-making process, they did identify two issues. First, some stakeholder groups that participate in SIM decision-making may also potentially be recipients of SIM-related contracts or grants (such as for PCMH Kids and Integrated Health Homes). The state has made sure to retain sole responsibility for the procurement process, to avoid any potential conflict of interest. Second, interviewees noted that achieving consensus from such a large and diverse group of stakeholders was time-consuming—and that the SIM Initiative has a schedule to meet. The SIM Core Team worked with the Interagency Planning Team and work groups to jumpstart the

⁸² State of Rhode Island. (2014). *Rhode Island State Healthcare Innovation Plan: Better Health, Better Care, Lower Cost*. Retrieved from www.eohhs.ri.gov/Portals/0/Uploads/Documents/SIM/SHIPFinal.pdf.

⁸³ <http://www.eohhs.ri.gov/ReferenceCenter/NoticesMeetingAgendas.aspx>

conversation by developing a ‘straw man’ for each key aspect of SIM planning, thinking through issues and potential questions committee members might raise before bringing items to the steering committee, and developing visuals—like the state’s Transformation Wheel⁸⁴ which illustrates SIM activities by domain and affected groups (e.g., PCPs, patients, community based organizations)—to better guide committee discussions and decisions. Project staff report that the steering committee worked more efficiently and quickly with examples and illustrations to which they could react, but still gave meaningful guidance to SIM planning. Going forward, steering committee and work group meetings will continue, although, depending on project needs, some work groups may be disbanded or new ones convened.

I.3.4 Delivery systems and payment reforms

The Rhode Island SIM Initiative’s delivery system transformation efforts are largely focused on supporting primary and behavioral health care providers practicing in PCMHs and Integrated Health Homes to deliver more integrated and coordinated care to children and adults. As of June 2016, about 400 providers at 73 practice sites participate in CTC-RI.⁸⁵ One member of the SIM project team described the Rhode Island SIM Initiative like this: “[although the SIM Initiative is not supporting payment reform directly], SIM is making investments in the providers [participating in value-based payment models] by helping them make the changes they need to make to impact the health care system—the hospital staff, PCPs, specialists, and community mental health center staff.” The state intends to use a combination of strategies to support PCPs and behavioral health professionals as they transition to value-based payment models. The two lead activities are PCMH Kids and training PCPs and behavioral health professionals on behavioral health integration practices. Many of the state’s delivery reform activities also have a workforce component, which involves training providers in new skills and processes. The state’s primary delivery reform initiatives are:

- ***Patient-Centered Model Home Kids.*** This program builds off the success of CTC-RI’s work on developing PCMHs for adults, by funding nine pilot practices to develop pediatric medical homes. SIM funding will support practice facilitation and provider coaching services, workflow redesign, and assisting practices with collecting and analyzing PCMH Kids measures and data. PCMH Kids, which Rhode Island Medicaid oversees, has secured participation from all four major health plans in the state—BCBSRI, Neighborhood Health Plan of Rhode Island, United Healthcare, and Tufts Health Plan.
- ***Behavioral health transformation support for primary care providers.*** Rhode Island SIM funds will be used to hire an experienced provider to provide training and coaching support to PCPs across the state to better integrate behavioral health

⁸⁴ <https://collaborate.rti.org/sites/sim2eval/Shared Documents/Model Test/State Folders/Rhode Island/State Documents/Other Background/SIM Transformation Wheel - Final.pdf>

⁸⁵ Care Transformation Collaborative of Rhode Island. (2014). *Care Transformation Collaborative Annual Report 2014*. Retrieved July 18, 2016, from <https://www.ctc-ri.org/sites/default/files/uploads/documents/annual-reports/CTC%202014%20Annual%20Report%20FINAL.pdf>

services into their practices. They will likely be trained on screening for depression, anxiety, and substance abuse; mechanisms for ensuring collaboration across specialties; and quality measurement and quality improvement practices. This activity will be complemented and supported by the state’s investment in SBIRT (see **Section I.3.6.**)

- ***Behavioral health transformation support for community mental health providers.*** In 2015, CMS awarded Rhode Island a Certified Community Behavioral Health Center (CCBHC) Planning Grant, which supports states in developing a plan for certifying and transitioning community mental health centers (CMHCs) to become CCBHCs.⁸⁶ The state is hoping to receive a CCBHC demonstration pilot award to expand implementation of the plan. If the state is successful in this, the SIM Initiative will fund a vendor for 3 years to provide coaching to CMHCs—to improve collaboration with PCPs, train providers on the use of health IT and data collection strategies, and implement modified quality improvement practices. Rhode Island’s behavioral health transformation support for CMHCs will also include implementation of a care management dashboard, to help clinic providers deliver more targeted health care services to clinic patients (see **Section I.3.5.**).

Most stakeholders were generally supportive of the Rhode Island SIM Initiative’s delivery system reform efforts. They viewed behavioral health integration as a laudable goal, as high expenditures and fragmented care for patients with behavioral health conditions were identified as key areas of concern for the state. One health plan interviewee noted that the state had experimented with behavioral health integration years earlier but had not had much success—which was attributed to a lack of training and coaching on integration practices. Given the SIM Initiative’s emphasis on provider education and technical assistance (TA), some interviewees anticipated that the state will have more success with integration than in prior years. However, despite being supportive of the concept of behavioral health integration, some interviewees expressed concern about new provider requirements stemming from the SIM Initiative. A number of federal and state efforts are directed at integrating primary care and behavioral health services—all of which mandate different requirements and activities.⁸⁷ “There is no overarching framework or clear standards for behavioral health integration,” expressed one interviewee. This presents challenges for compliance and implementation.

I.3.5 Health information technology and data infrastructure

Prior to SIM implementation, Rhode Island supported a robust health IT infrastructure, as noted. Although several stakeholders reported the state was fairly advanced in health IT, however, some reported the system could be more aligned throughout the state. As one provider

⁸⁶ SAMHSA. (2015). <https://www.samhsa.gov/grants/grant-announcements/sm-16-001>.

⁸⁷ Several federal and state delivery system reform efforts that health care providers in Rhode Island are participating in address behavioral health integration. These efforts include health homes as authorized by the ACA, integrated health homes (the state’s pilot health home initiative), the CCBHC demonstration program (overseen by SAMHSA), and PCMHs, which also include select standards for behavioral health integration.

put it: “not all hospitals are on the same [health IT] system, and there’s no overarching way of doing things.”

A highlight of the state’s health IT system is the APCD, HealthFacts RI, which is mandatory for all payers by statute.⁸⁸ The system—which is jointly managed by EOHHS, the Rhode Island Department of Health (RIDOH), OHIC, and HealthSource RI—contains de-identified data for all Rhode Islanders, with individuals able to opt-out if they do not want their data included in the APCD. Three major vendors are involved in development and maintenance of the APCD: (1) Freedman Health Care serves, as project management vendor; (2) On Pointe, as data aggregator for payer files; and (3) 3M, as analytic vendor that generates data reports for the state. The APCD covers data from 2011 through 2014.

Rhode Island has a state-designated health IT entity, the Rhode Island Quality Institute (RIQI), which has overseen and administered the statewide HIE since 2010. Work on the HIE began in 2004, when Rhode Island pursued an Agency for Healthcare Research and Quality (AHRQ) state demonstration project to support a statewide HIE. At that time, RIQI provided the community governance structure for administering the HIE, with the intent of having the community (as opposed to the state) oversee it. In 2008, the state HIE was passed into law as CurrentCare. In 2010, the grant ended and the state then transferred the entire administration of CurrentCare over to RIQI.

To participate in CurrentCare, individual consumers must opt-in. The process has been made consumer friendly by allowing many Rhode Islanders to engage in the opt-in process in their doctor’s office. Providers can access consumer records at three levels: (1) emergency only, (2) all treating providers, or (3) both. As of June 2017, there are approximately 435,000 individuals enrolled, constituting over 50 percent of the state’s population.

Data transferred over CurrentCare include hospital laboratory, medication, continuity of care document summary, and radiology data. Individuals are able to access the information via a web portal. The portal now has bi-directional access, so providers can see data through their own EHRs as well. RIQI also provides alert notifications to health care providers on admissions and discharges—serving as the intermediary for transferring these alert notifications through business associate agreements with all hospitals in the state. Providers are able to receive these alerts for their entire patient panel if they provide RIQI with the requisite patient information.

⁸⁸ A memorandum to the APCD Interagency Work Group from Rhode Island General Counsel clarifies that *Gobeille v. Liberty Mutual*, which excludes those who are self-insured from sending data into state APCDs, does not apply to the Rhode Island APCD, as it does not (1) impose reporting requirements on self-insured employers subject to the Employee Retirement Income Security Act, or (2) contain personally identifiable information; and it provides individuals with an opportunity to opt out. All-Payer Claims Database Council. (2016, March 29). Memorandum: Applicability of the *Gobeille v. Liberty Mutual* decision to Rhode Island’s APCD. Retrieved September 8, 2016, from http://www.apcdouncil.org/sites/apcdouncil.org/files/media/ri_apcd_gobeille_3_29_2016.pdf.

Other health IT initiatives present in Rhode Island prior to the SIM Initiative, as noted, include a patient dashboard and a planning effort for a provider directory. RIQI received a grant to build a patient dashboard for use by providers, which includes a patient panel, discharge data, and other relevant information on patients. The Trailblazers Initiative, a learning collaborative, incubated the concept of a statewide health care provider directory, and developed a set of use cases to demonstrate the uses of a provider directory and its value to a variety of stakeholders.

SIM funding is being used to support pre-existing health IT initiatives, expand the use of existing health IT initiatives, and support development of new health IT process to improve care, as follows:

- ***All-payer claims database.*** SIM funding is financially sustaining the three major APCD vendors, so the state can begin to determine how best to use the data and perform more useful analytics. Goals include more closely reviewing utilization patterns and cost of care. The state also plans to use SIM funding to create practice-level reports. In addition, the state plans to begin making data available for purchase to researchers, though not necessarily with SIM funding.
- ***Behavioral health care management dashboard.*** SIM funds will be used to purchase the electronic dashboard developed by RIQI for the CMHCs. SIM funds will be used to pay a one-time connection fee required to link the CMHCs' patient panels to the dashboard. Ongoing funding for operation of the dashboard will come through a per member per month fee for the CMHCs. The dashboard will identify CMHC patients and inform providers in real time when patients access emergency room (ER) and inpatient hospital services. This prompt information sharing is expected to facilitate targeted, appropriate clinical interventions, improve care coordination, and reduce hospital readmissions. SIM funding will also cover the cost of training providers in use of this new technology. The state plans to leverage the dashboard by using SIM funds to link the CHTs to the dashboard and improve care coordination for individuals with behavioral health needs. The state is also leveraging an additional grant, separate from the SIM Initiative, to link PCMHs to the dashboard.
- ***Statewide common provider directory.*** The provider directory is a web-based database that will have detailed provider information—including demographics and contact information; and provider relationships to practices, hospitals, accountable care organizations (ACOs), and health plans. SIM funding will help operationalize this directory and begin implementation. The state was expecting data extracts to become available in summer 2016, but did not expect full payer participation at that time. The state anticipates going live with a public portal of the provider directory in 2017.
- ***Quality measurement, reporting, and feedback system.*** This process is intended to collect standardized data across state agencies, payers, and providers—to improve quality of care for patients, provide more accurate quality measurement, leverage analytic expertise for reporting, create a central location for reporting, and increase transparency and patient engagement. It is intended to standardize measures, reduce duplication, and allow analysis of data already being input into existing systems,

rather than create entirely new systems. As a part of this effort, SIM funding also provides administrative support for the Measure Alignment Workgroup. This work group—comprising payers, providers, measurement experts, consumer advocates, and other community partners—is responsible for developing and advising on the implementation process for aligned quality measures for ACOs, PCPs, and hospitals. Thus far, this work group has created an aligned measure set with 59 measures. Included within the menu are core measure sets for ACOs (11 measures), PCPs (7 measures), and hospitals (6 measures).⁸⁹

- ***Integrated health and human services data ecosystem.*** SIM funding will be used to support development of a modern system for integrating person-level information across Rhode Island’s EOHHS agencies (Medicaid, the Department of Behavioral Health, Developmental Disabilities and Hospitals; the Department of Children, Youth, and Families; the Department of Human Services; and RIDOH). The goal of building this system is to access state databases and find ways to use them to drive policy. The state also wishes to build internal capacity to analyze data for informing policy decisions.

Many stakeholders have voiced support for the state’s plans to use SIM funding to support health IT initiatives. Many, regardless of their involvement with the behavioral health community, expressed support for the behavioral health care management dashboard and increased use of data analytics. One stakeholder stated, “Any additional support to get the state’s health information exchange to be more useful, user-friendly, more doctors involved in using it, would be a plus to us.”

Despite advances of the Rhode Island health IT system and the initiatives supported by the SIM Initiative, several respondents reported that challenges and opportunities still exist in the health IT due to the absence of a state health IT strategic plan. Rhode Island currently does not have an overarching health IT strategic plan. State agencies have individual plans; according to state officials; however, these plans do not align as well as they could. The absence of an overall plan is perceived to lead to three other major challenges:

- ***Duplication of reporting efforts.*** Perhaps related to the absence of a state strategic plan, state officials reported the state tends to have a great deal of duplicate health IT efforts occurring across the state, due to regulatory and policy limitations (e.g., privacy constraints; see next bullet). These limitations prevent data linkages that would reduce duplication in reporting. As one stakeholder summarized the situation: “It’s probably a big challenge to figure out where we work together, try to avoid wasteful overlap, and preserve space for providers and plans to be innovative and compete.”

⁸⁹ Many stakeholders report alignment as an important effort. One stakeholder perceived “measure alignment as a component of the SIM Initiative that will have real impact” and that reducing the metrics providers are required to report as having “a lot of value to the state.” Another stakeholder also reported perceiving value in alignment efforts, but cautioned that measure alignment may be difficult due to competing requirements, and sees difficulties continuing until there is legislation requiring it.

- ***Data sharing challenges associated with privacy laws.*** State and federal privacy laws, particularly ones associated with provision of behavioral health services, prevent sharing of data and coordination of care. One stakeholder noted, “The behavioral health community does not use the APCD due to privacy laws.” The same stakeholder further indicated that, for CurrentCare to be compliant with *Code of Federal Regulations* 42, Part 2 in sharing behavioral health information, providers must obtain consent from the patient every time they attempt to access data. Despite these privacy-related challenges, it should be noted that the state has developed a workaround for the Behavioral Health Care Management Dashboard, in which behavioral health data are separated from physical health data and include privacy warnings. The state reported that SAMHSA considers this to be compliant with federal privacy laws.
- ***Challenges in leveraging health IT to support value-based purchasing.*** The state considers it a key challenge to determine how value-based purchasing can be used to improve population health and overall health outcomes. The state hopes to leverage SIM funding to improve its use of data analytics to support the provision of high quality health care.

One SIM opportunity stakeholders noted in the health IT arena is fostering collaboration. Stakeholders thought the SIM Initiative will facilitate better alignment across agencies. SIM work is supporting more interagency projects than the state has had in the past. Also, state officials perceived closer working relationships across agencies than in the past, which are facilitated by good leadership at the Governor’s and the state official’s level.

I.3.6 Workforce development

Rhode Island’s SIM Initiative includes a range of projects aimed at making investments in the state’s health care workforce. Many of these projects develop supports to more effectively deliver behavioral health services. Projects outlined in the state’s draft Operational Plan are briefly described below.

Community health teams are multidisciplinary teams that provide health coaching and care coordination services to support PCPs in delivering value-based care and address the social and environmental determinants of health that affect the most vulnerable Rhode Islanders. CHTs are staffed by community health workers (CHWs), and may also include behavioral health providers, nurses, licensed pharmacists, and nutrition professionals. CTC-RI piloted CHTs in 2013 at South County Hospital and Blackstone Valley Community Health Care, with funding from health plans, RIQI, and EOHHS. These CHTs were designed to address the needs of patients with comorbid behavioral and physical health conditions.

SIM resources will be used to support and expand the CHT workforce in three ways. First, SIM resources will be used to fully fund two new CHTs, which will be “payer agnostic.” That is, they will provide services to community members regardless of insurance coverage—unlike existing CHTs, which serve only patients with certain types of coverage. Second, SIM

resources will be used to enhance the capacity of all CHTs, including existing ones. Although the specifics of this support are still being developed, SIM staff are fleshing out several strategies. For example, SIM resources may be used to develop a care management dashboard, train CHTs on its use, and support them in incorporating the training into their work flows. SIM resources may also be used to investigate the possibility of establishing centralized statewide CHW training and professional development. Third, SIM resources will be used to provide training and support to the health care providers who work with CHTs (e.g., PCPs, CMHCs, and hospitals) to help them more effectively incorporate CHTs into their workflows.

The Child Psychiatry Access Program is modeled after a Massachusetts program that established regional mental health consultation teams to provide consultation and referral services to pediatricians, through phone and telemedicine linkages. The program will support pediatricians in responding to children with immediate behavioral health needs, by providing pediatricians with consultation and response to emergent situations. In addition to helping PCPs address the immediate need, over time the consultations are expected to extend the range of behavioral health needs PCPs can address within their own practice. A second aspect of this program is ongoing physician training to help them better identify and meet their patients' behavioral health needs, including training on behavioral health screening.

The state's plan for **behavioral health transformation** consists of supports for practice transformation at primary care practices and CMHCs. In addition to those supports, described in *Delivery and Payment Reform, Section I.3.4.*, this plan includes a workforce element. SIM resources will be used to train providers to deliver SBIRT to patients at risk for substance use disorders. SIM funding will be supplemented with the recently awarded SAMHSA grant, which will support: (1) health educators and health navigators targeting Federally Qualified Health Center patients and (2) individuals discharged from state Department of Corrections facilities.

A final workforce strategy is to convene a learning collaborative of providers and payers engaged in implementing value-based payments and APMs. Collaborative participants will learn about and discuss best practices around contracting and implementation of these models.

While stakeholders generally agreed the state should focus on shoring up the behavioral health system through workforce investments, impressions were mixed about how successful the individual workforce efforts will be. Several stakeholders believe the Child Psychiatry Access Program will be the most successful SIM component, and will be easily sustained after SIM funding has ended. Perceptions were also mixed regarding CHT success. Some said they are excited by the CHT potential to enhance the workforce. But some expressed concern that these teams will not be sustainable once SIM funds are not available; and at least one stakeholder sounded dubious that the CHT model will succeed at all.

I.3.7 Population health

Rhode Island refers to its SIM population health plan as the Integrated Population Health Plan. At the time of the site visit, the state had submitted a draft Operational Plan to CMS, with the Integrated Population Health Plan significantly less developed than other parts. Following the 2016 site visit, the state completed a revised version of its population health plan at the end of June of that year.

Rhode Island's approach to population health seeks to promote whole-person care and wellness across the life course. The state's Integrated Population Health Plan focuses on the following priority conditions: tobacco use, obesity, chronic disease (including diabetes, heart disease, and stroke), depression, children with social and emotional disturbance, SMI, and opioid use disorders.

Rhode Island encountered two design challenges in developing its SIM population health plan. Before Rhode Island received the SIM award, the RIDOH had already been tasked with developing a comprehensive population health plan for the state. Also prior to receiving the award, Rhode Island had established numerous efforts to address the state's priority conditions. These two efforts created challenges to developing a population health plan specifically for the SIM Initiative. SIM staff did not want to develop a plan for the SIM Initiative that duplicated the planning efforts already under way at the RIDOH. Rather, the SIM staff wanted the SIM population health plan to bring added value to the many efforts already in place in Rhode Island to address the priority conditions selected for the SIM Initiative.

Ultimately Rhode Island addressed these challenges by developing the Integrated Population Health Plan. This plan fulfills both the SIM requirements and the RIDOH population health planning requirement. It aligns with and augments the existing activities to address priority concerns. For example, the SIM Initiative is aligning with an existing RIDOH tobacco control plan, Wellness Recovery Action Plans, and motivational interviewing to address tobacco use. The state has also incorporated the following tobacco measures into CurrentCare (the State's HIE): current adult smoking status; attempts at smoking cessation in the past year; percentage of high-school students who use tobacco products; and smoking behaviors among women before, during, and after pregnancy.

Since Rhode Island is seeking to devote most of its SIM resources to improving behavioral health, the state has included a few specific behavioral health conditions in the Integrated Population Health Plan, and explicitly calls for an “any door is the right door” approach to improving the health of Rhode Islanders with behavioral health needs—a phrase chosen to convey the intent to improve the state health care system by ensuring that, no matter where individuals with behavioral health needs enter the system, the providers serving them will be equipped to identify their specific needs and help them access evidence-based treatment for those conditions. In this way, the SIM Initiative hopes to help people with behavioral health

conditions recover quickly, create healthy communities, and help all Rhode Islanders live healthy lives and become fully included in their communities.

I.3.8 Technical assistance and other support resources

Several interviewees (including non–state official steering committee members) described CMS’s site visit to Rhode Island in May 2016 as very helpful. In particular, interviewees noted the CMMI group director’s presentation to the steering committee as useful in explaining CMS’s vision for the SIM Initiative, and help the state understand adjustments it could make to its Operational Plan. The team also appreciated CMS’s investment of SIM dollars in the state, and said that without the SIM award, the state “wouldn’t have been able to achieve the level of coordination that we have now across state agencies.”

The SIM Core Team has also become more familiar with how TA resources available through CMS contractors can support its work. TA the state has received from the Center for Health Care Strategies, the National Governor’s Association, and the Office of the National Coordinator for Health Information Technology (ONC) were cited as valuable. For example, ONC has helped the SIM team with ongoing health IT support and research on the state’s current activities.

I.3.9 Progress, challenges, and lessons

Progress

Rhode Island initially experienced delays securing staff and getting the steering committee to come to consensus. However, after changes in staffing at the state level, the steering committee was able to move forward with their work. The state is currently engaged in numerous procurements, both competitive (e.g., CHT training) and sole source (e.g., behavioral health transformation care management dashboard).

Challenges

Most of the challenges Rhode Island encountered over Year 1 of the SIM Initiative were administrative: slow staffing and procurement processes, a lengthy stakeholder consensus process, and the need to adjust project scope due to the smaller than anticipated SIM funding amount. The state also encountered challenges in developing a population health plan that aligned with pre-existing population health efforts. In addition, concerns were starting to emerge during the 2016 site visit about two issues: (1) the impact of federal privacy laws on efforts to support behavioral health integration through health IT; and (2) sustainability of SIM activities (e.g., CHTs and practice coaching) after SIM funding ends.

Lessons learned

Rhode Island has dealt with many of the challenges encountered during the first year. The state secured staff and key contractors, achieved stakeholder consensus on critical implementation decisions, made progress in aligning SIM activities with the multiple delivery

system reforms and population health initiatives under way, and identified resources to help mitigate the effect of the lower than anticipated award amount. Lessons have begun to emerge from Rhode Island’s SIM implementation to date. Lessons most frequently mentioned by stakeholders include:

- ***An experienced project director dedicated solely to the project was able to create rapid progress.*** Many interviewees noted that hiring a dedicated project director contributed greatly to the state’s progress in implementing the SIM Initiative—in particular, the project director’s leadership and experience in state government and community organizing has been instrumental.
- ***The matrix staffing model promoted cross-agency coordination.*** Rhode Island’s multi-agency matrix staffing model helped the state to coordinate relatively seamlessly across five agencies and multiple initiatives. One SIM Core Team member reported, “If we were all working for one organization, it would not have worked. The staffing [model] was critical to get decisions in a short amount of time, be nimble, [and] understand the landscape.”
- ***Meaningful stakeholder engagement is an important, yet time-consuming process.*** Stakeholder engagement is a cornerstone of policymaking in Rhode Island, and many interviewees said that it was important to foster a sense of community ownership of the SIM Initiative. While obtaining consensus on a large scale is challenging, state officials were proud that they have been able to achieve it on all Steering Committee decisions so far. They attributed their success to multiple factors including: selection of a well-respected health plan executive to co-chair the Steering Committee; identifying the best point to bring plans to stakeholders, to enable them to provide guidance without wasting their time; and developing tools to help manage decision-making, such as the Transformation Wheel described earlier.
- ***Resources can be maximized by aligning efforts and avoiding duplication.*** Rhode Island has used SIM funding to develop supports that align with and further the state’s ongoing efforts with other payment and delivery system reforms (e.g., Reinventing Medicaid, Medicaid’s re-bid of its managed care contracts, and developing the Accountable Entities pilots). SIM funding has been leveraged to support state goals including better integration of physical and behavioral health, improved care, and lowered costs. Similarly, as of June 2016, SIM project staff are engaged in selecting strategies for improving population health that will align with, and support, the many existing population health efforts in the state. State staff expressed excitement about SIM’s potential to expand and augment these existing population health resources.

I.4 Statewide Changes

I.4.1 Health care expenditures and utilization

One of the aims outlined in the draft Operational Plan is to reduce the rate of increase in state health care spending. As yet, however, the state has not articulated goals or metrics for how it will determine SIM’s impact on expenditures and utilization.

Many stakeholders cited issues of access to outpatient behavioral health services as leading to lower than expected utilization of mental health and substance abuse outpatient treatment. Additionally, stakeholders expressed the opinion that current hospital and ER utilization for individuals with behavioral health concerns is too high—which they see as being potentially reduced by such SIM components as the behavioral health dashboard and the Child Psychiatry Access Program. The state also perceives that the CHTs will aid in reducing hospital and ER utilization for individuals with SMI, thereby reducing cost.

I.4.2 Care coordination

By many reports, Rhode Island has a fairly well-developed system of care coordination. CTC-RI, the state’s PCMH initiative, serves over 30 percent of the state’s residents. Many stakeholders—including consumers, providers, and payers—cited several examples of CTC-RI’s successes, and provided specific examples of care coordination. In one focus group conducted with behavioral health consumers, virtually all participants indicated they had received a referral from their PCP to smoking cessation treatment and nutritionists, and to assistance with exercise programs—indicating high-quality care coordination.

Through the SIM Initiative, Rhode Island aims to build on its previous investments in care coordination. This goal is an implied objective of all the state’s SIM delivery system reform and health IT interventions. However, the key activities the state identified as most likely to have an impact on care coordination are the state’s expansion of PCMH for Kids, behavioral health transformation activities, and planned implementation of the two additional CHTs. State officials noted the important role PCMHs play in incentivizing better communication and care coordination among providers. One state official described “Paying for value” as an essential approach to improving care coordination and changing the health care delivery system.

The state’s behavioral health transformation activities consist of training for PCPs and behavioral health providers, on how to better serve patients with mental as well as physical health conditions. Some stakeholders were skeptical about the feasibility of successful integration, and whether or not it will have the intended impact on care coordination, as envisioned by state officials. At least one reason given for skepticism is lack of a clear *direction* and vision for what successful integration entails. The one behavioral health transformation approach many stakeholders believed can have a clear impact on care coordination is the real-time care management dashboard to be installed throughout the state’s CMHCs (see ***Health Information Technology and Infrastructure Development, Section I.3.5.***). Several providers noted that receiving alerts on patient ER visits and admissions will help facilitate care coordination for patients with behavioral health conditions, because it will make it easier for physicians to follow-up with individuals who need additional care.

Lastly, Rhode Island intends to allocate SIM funds to create two new CHTs allocated to high-risk patients in areas with significant unmet need. As envisioned by the state, these CHTs

are designed to deliver more coordinated and integrated care to patients with unaddressed social and behavioral needs. Although CHTs may improve care coordination for the individual patients they are serving, however, many stakeholders did not view them as necessarily sustainable or as impactful as other SIM interventions. At least according to one interviewee, although CHTs bring new health care professionals into the system, this can be costly and has not necessarily been shown to improve quality.

Currently, the state is not tracking progress on its own measures to determine the effectiveness of its care coordination interventions; however, there are several stated outcome goals for improved care coordination, particularly for individuals with behavioral health concerns. These outcome goals include a reduction in hospital re-admissions and reduced use of ER for usual source of care for individuals with SMI. Additionally, SIM's behavioral health transformation component includes several stated outcomes for the SMI population—including decreased smoking, reduced body mass index, increased healthy eating, and increased physical exercise.

I.4.3 Quality of care

Stakeholders expressed generally positive views about the quality of the state's health care system, but somewhat mixed views regarding specific subtypes of care. The majority of stakeholders indicated that recent health care transformation efforts, such as PCMHs for adults, have had a positive impact on primary care in the state. One stakeholder put it this way: "The health care system in the state has come a long way over the past 10 years, certainly in past 5 years, in transforming traditional medical practice, hospital practice, and outpatient practice into a more transformed, team-based model, especially in primary care communities." Other stakeholders concurred with the positive views of primary care; however, some were concerned about lack of specialist involvement in health care transformation activities. Some also provided a dissenting view with regard to services for individuals with behavioral health issues, with one stakeholder describing a "wall between the behavioral health community and the primary care community." This stakeholder felt key components of the SIM Initiative to be the state's attempts to address the lack of communication between the behavioral health and primary care communities, and cited PCMH Kids and the Child Psychiatric Access Program as important components of transformation for the state.

Providers, payers, and consumer advocates consistently indicated that quality of behavioral health care can be improved, citing recent cuts in reimbursement and organizational changes as having a negative impact. Focus groups of providers and consumers of behavioral health services described such indicators of poor care as long wait times and lack of providers, particularly for addiction treatment. However, as noted, many behavioral health consumers mentioned receiving care-coordination services such as referrals to smoking cessation treatment and nutritionists, and assistance with exercise programs.

One stakeholder indicated that an area of quality that requires additional attention in Rhode Island is patient experience of care, specifically access to care. The stakeholder felt that children's health issues do not seem to be a SIM priority and noted children's health needs included access to services, continuity issues, and transition issues. A state official indicated the state is aware of access to care issues for children and explained that the state is reactivating its Children's Cabinet to improve the pediatric behavioral health care experience by actively reviewing barriers to access to care.

The need for additional focus on access to care was echoed by other stakeholders as a primary area of concern for behavioral health services. One behavioral health stakeholder discussed perceived struggles with patient experience of care and access to care, due to difficulties convincing primary care doctors to participate in team-based PCMH care.

One state official indicated that including social and environmental determinants of population health is crucial for the SIM Initiative to be successful. The same state official indicated ensuring access to quality health services, especially for vulnerable populations, is also a primary concern for the state, stating "health should not be dependent upon a zip code."

To improve the perceived lack of quality in the behavioral health system, one primary focus of the SIM Initiative is to integrate the behavioral health system into the strategies that have been successful for physical health care in the state. As noted, Rhode Island is strategically using SIM funds to strengthen and further integrate behavioral health services through a plan for behavioral health transformation—which includes the Child Psychiatric Access Program, CHTs, expansion of SBIRT to improve substance use disorder screening efforts, improved behavioral health quality, and behavioral health workforce development (known as the Practice Transformation Coaching Program). The focus on strengthening behavioral health services has spilled over to the state's population health plan. The state is continuing to develop its Integrated Population Health Plan, which will further inform the activities outlined in the state's Operational Plan.

As previously described, a Measure Alignment Workgroup created by the SIM Steering Committee has created an aligned quality measure set with 59 measures, which include a subset of core measures to be required in all performance-based contracts. Health plans and providers may also select additional measures from the measure set for inclusion in contracts. The work group has not yet developed requirements for public reporting or thresholds for the core measures. Stakeholders see the measure alignment process as an important SIM component in reducing the administrative burden on providers, and a critical component of value-based purchasing.

Several stakeholders defined SIM quality of care in terms of increased integration of behavioral health and PCPs. One stakeholder echoed the views of others for a successful SIM project: "if we can get a significant increase of behavioral health providers integrated into

primary care practices and more Rhode Island residents into behavioral health/primary care practices, that would be one element of success.” There were, however, varying opinions related to whether this can be achieved during the SIM timeframe. Some stakeholders were hopeful, but indicated that the SIM Initiative is a short-term project and may not be sustainable. One specific concern was that while the SIM workforce activities will be helpful, the size and scope of the activities will be difficult to sustain.

A minority of stakeholders expressed concern that the SIM interventions do not have a holistic view and are not part of an overarching plan for behavioral health services. One group of interviewees expressed frustration, perceiving the plans to be based on assumption of needs and not on an assessment of existing behavioral health services available in Rhode Island. As an example, these interviewees mentioned that SIM efforts included allocation of funds for a child psychiatry access line and training the CMHCs. But, according to this group, these strategies will ultimately not be successful because they are not within the context of a vision or an overarching plan.

I.4.4 Population health

The state’s approach to population health, which integrates physical and behavioral health, was the main focus of interviewee comments regarding population health. (Also, as noted previously, the Integrated Population Health Plan was one of the less developed parts of the draft Operational Plan.) State officials stressed their view that behavioral health was deeply connected to outcomes for chronic and acute health conditions, citing that people with SMI die approximately 25 years earlier than average due to chronic diseases like heart disease, diabetes, and obesity. Opinions varied among interviewees, however, about the readiness and capacity of behavioral health providers to meaningfully participate in system transformation efforts that will promote population health. One state official said that many CMHCs are “stuck” in an older, FFS-driven system and have not experienced health reform in the way the rest of the health care system has.

Several participants in a focus group of behavioral health providers described CMHCs as having operated with reduced resources over the last 5 to 10 years. One cited a need for streamlined treatment approaches for behavioral health providers: “it doesn’t seem like there’s this overarching framework for everyone to do, it seems like everyone is figuring out how to do it on their own, which isn’t all that efficient. It would be helpful if we had a system in place that seemed to be working and we were all applying it in a similar way.” While many stakeholders said there is a willingness among providers to provide integrated behavioral health services and a belief that the SIM Initiative is providing some good tools to support system transformation, a small number of interviewees questioned whether the state might be more successful by concentrating on working with a smaller number of larger, more integrated health systems.

Interviewees indicated that “success” with population health will be gauged by whether the state can achieve integration of behavioral health and primary care, and whether the SIM-funded CHT pilots, PCMH Kids, and the Child Psychiatry Access programs work for Rhode Islanders. If the state finds these strategies have not been effective in addressing behavioral health needs, one behavioral health provider stressed that it will be important for the state to reassess its vision to meet patients’ needs and find appropriate funding to achieve its vision.

The state will measure progress toward its population health goals through the work of the Measure Alignment Workgroup, which includes among its population health metrics such items as rates of diabetes, obesity, tobacco use, and depression. All measures will be updated and reviewed annually.

I.5 Overall Rhode Island Summary

During Award Years 24, Rhode Island is aiming to use SIM funding to complement prior efforts to transform its health care delivery system, through improving population health and supporting the statewide health care delivery system. In particular, the state plans to build on prior transformation successes by making significant investments in the health care workforce and health IT.

One of the core components of the Rhode Island’s SIM Initiative is integration of physical and behavioral health. Rhode Island’s SIM Operational Plan⁹⁰ addresses behavioral health transformation, which includes the Child Psychiatric Access Program, CHTs, expansion of SBIRT to improve substance use disorder screening efforts, improved behavioral health quality measurement, and behavioral health workforce development. Stakeholders universally expressed support for this focused use of funding.

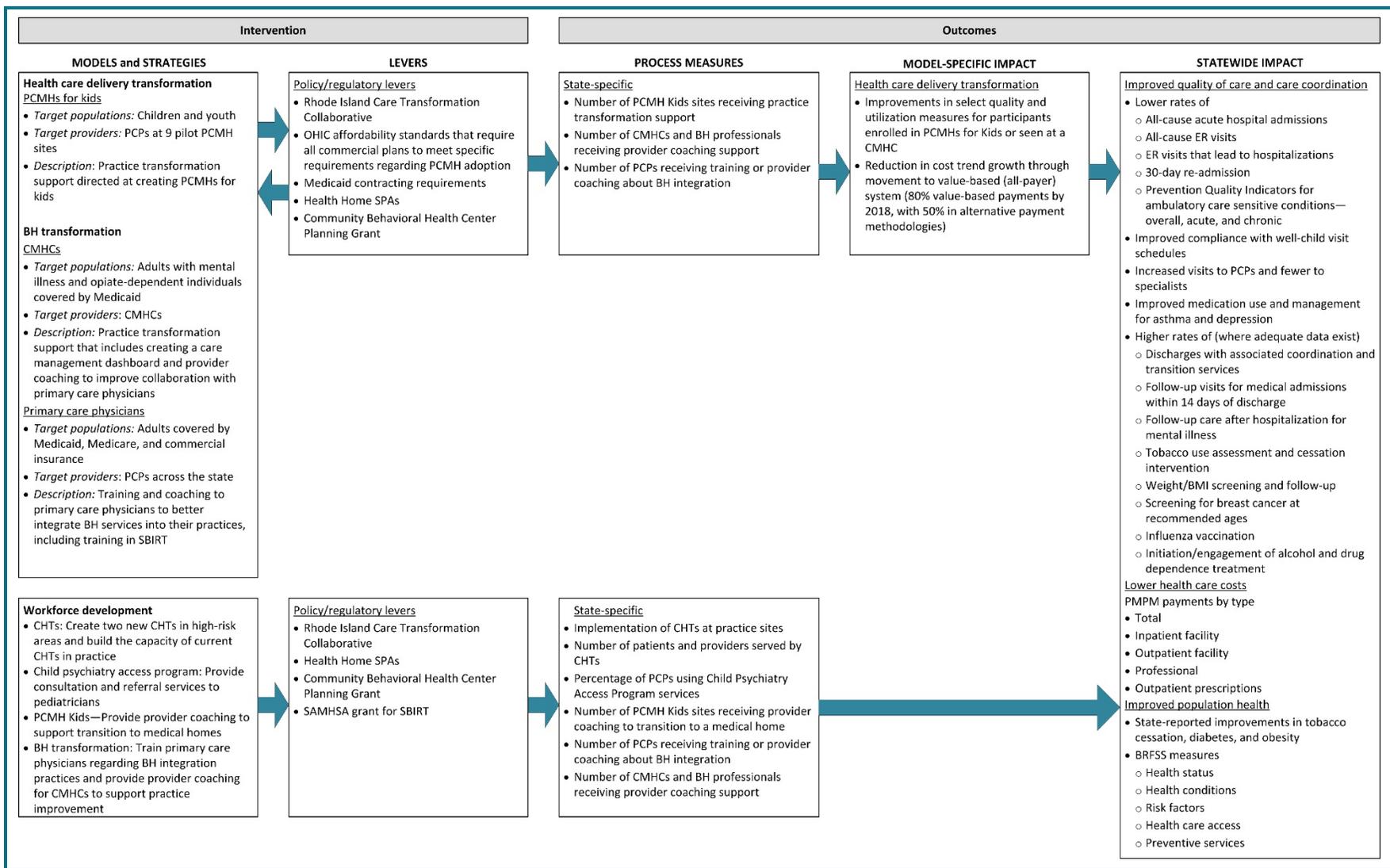
Data gathered from interviews with state officials and other stakeholders during the Year 1 site visit indicate the state is engaged in an excellent planning process to improve population health, integrate behavioral health into the physical health care system, and increase the use of APMs in the state.

Challenges remain, such as sustainability—particularly in terms of supporting SIM elements such as the CHTs, PCMH Kids, and the Child Psychiatry Access program beyond the SIM funding cycle. However, state officials and stakeholders frequently cited several successful components they say will assist the state in achieving the SIM Initiative’s goals—including the sound structure of SIM governance, the strong collaboration between the state and stakeholders, the state’s successful history of health care reform efforts, and strong support from the Governor’s office and other key state officials.

⁹⁰ State of Rhode Island. (2016, April 28). *Rhode Island State Innovation Model (SIM) Test Grant: Operational Plan, Version 1*. Retrieved from <http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/State%20Innovation%20Model/RISIMOperationalPlanVersion1April282016.pdf>

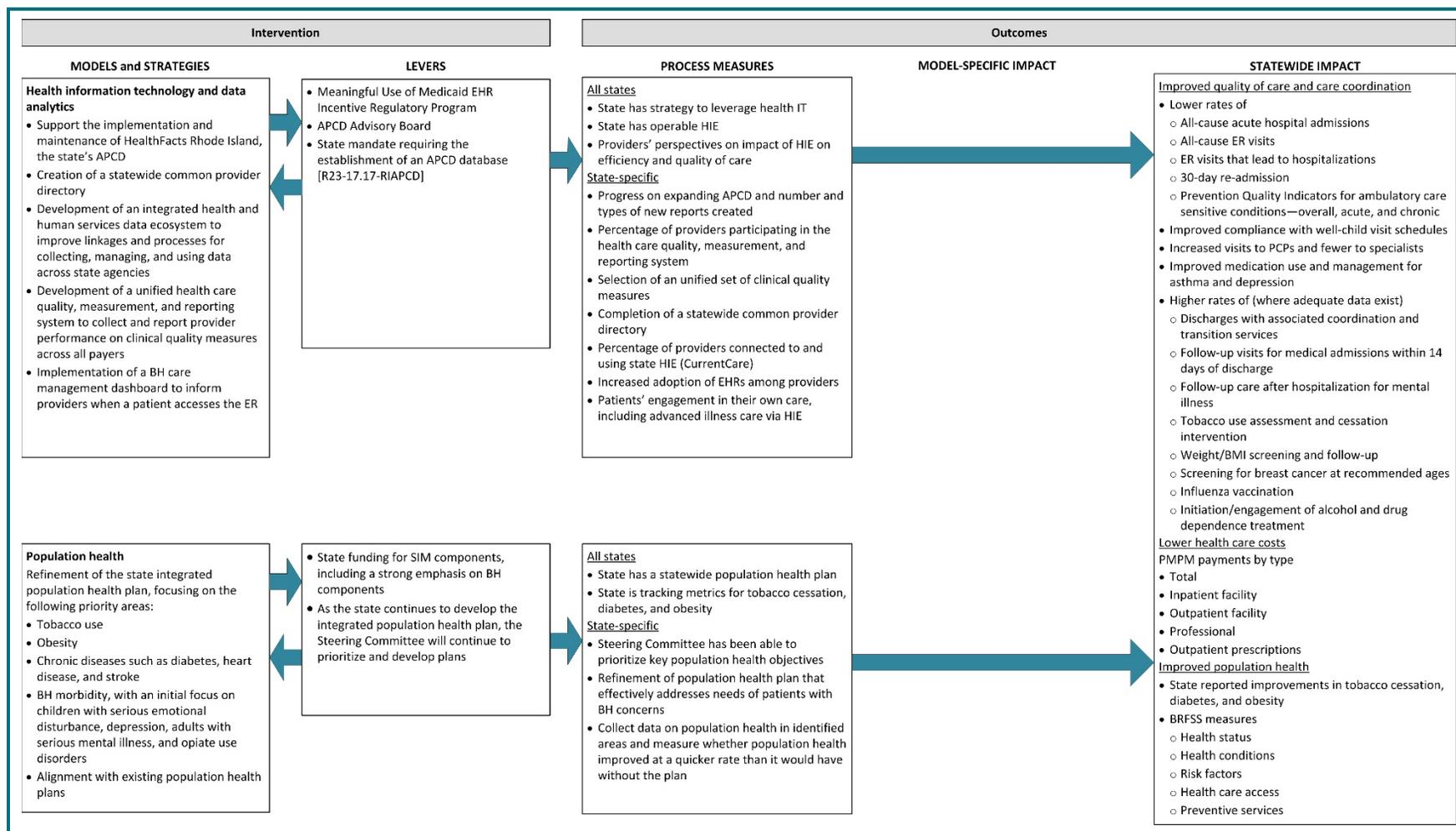
Figure I-1. Logic model for Rhode Island’s State Innovation Model activities

I-26



(continued)

Figure I-1. Logic model for Rhode Island’s State Innovation Model activities (continued)



I-27

APCD = all-payer claims database; BH = behavioral health; BMI = body mass index; BRFSS = Behavioral Risk Factor Surveillance System; CHT = community health team; CMHC = community mental health center; EHR = electronic health record; ER = emergency room; health IT = health information technology; HIE = health information exchange; OHIC = Office of the Health Insurance Commissioner (Rhode Island); PCMH = patient-centered medical home; PCP = primary care provider; PMPM = per member per month; SBIRT = Screening, Brief Intervention, and Referral to Treatment; SIM = State Innovation Model; SPA = state plan amendment.

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Appendix J: Tennessee Site Visit Report

During the 2016 site visit, which took place from May 31 through June 2, the RTI team conducted 13 key informant interviews in the greater Nashville and greater Memphis areas of Tennessee. The team also conducted five telephone interviews after the site visit, for a total of 18 interviews. The purpose of the interviews was to learn about the context of the state's health care system and early SIM implementation successes, challenges, and lessons learned. Interview participants included state officials from state agencies or departments; and representatives from payers and purchasers, consumer advocate organizations, and provider organizations involved in the development and implementation of Tennessee's SIM Initiative.

During the site visit, the team also conducted two focus groups with consumers and two with providers—to learn about their experiences with the current health care system in the state, and their awareness, if any, of the SIM Initiative. In these focus groups, the RTI team spoke with Medicaid beneficiaries and primary care providers (PCPs), both in Memphis and with PCPs in Nashville.

This appendix provides an overview of the Tennessee SIM Initiative; describes the current health care context in which the SIM Initiative is being implemented; summarizes major early implementation successes, challenges, and lessons learned; and discusses key findings from the site visit interviews and focus groups organized by major topical area. This appendix includes findings based on qualitative data collected through June 30, 2016. Further details on the analytic approach are available in *Appendix L*. Information on the site visit interviewees for the state is in *Table L-1*, and information on the provider and consumer focus group participants for the state is in *Tables L-4* and *L-5*, respectively.

J.1 Overview of Tennessee's State Innovation Model

The Tennessee SIM Initiative was launched in 2013, to reform health care payment and delivery in the state and shift to a health system grounded in value-based payment (VBP). Health system transformation under the SIM Initiative comprises three overarching strategies:

- ***Episodes of care.*** By 2019, the state expects to have implemented 75 designated episodes of care (EOCs), tied to acute health care events such as a surgical procedure. The episodes will be implemented in 11 waves. Each will hold one key provider accountable for the overall cost and quality of care provided by multiple providers around that health event. Wave 1, covering three episodes, went into effect in May 2014.
- ***Primary care transformation.*** Tennessee will develop initiatives that promote the role of the PCP in managing chronic diseases and delivering preventive services. This strategy includes three components: (1) an aligned, multi-payer model of patient-centered medical homes (PCMHs); (2) Health Link to serve as health homes for high-risk Medicaid (called TennCare in Tennessee) beneficiaries with acute behavioral

health needs; and (3) a provider-facing care coordination tool (CCT) that includes admission, discharge, and transfer (ADT) data for attributed providers. Twenty-five PCMH practices are scheduled to launch for TennCare members in January 2017, which the state aims to build into a statewide aligned commercial and Medicaid PCMH program. Health Link will launch in fourth quarter 2016.

- ***Long-term services and supports.*** Tennessee will build its SIM long-term services and supports (LTSS) program on existing initiatives focused on improving quality and shifting to VBP for nursing facility and home- and community-based services (HCBS) for (1) older adults and adults with physical disabilities, and (2) individuals with intellectual and developmental disabilities (I/DD). This will include a standardized quality measure framework, a new reimbursement structure for enhanced respiratory care services, and workforce development around knowledge and competencies.

J.2 Logic Model

Figure J-1, located at the end of this appendix, is a logic model of the Tennessee SIM Initiative depicting the hypothesized relationship between specific elements of the SIM Initiative and changes in outcomes. Column 1 describes the models and strategies being implemented under this initiative. These include health care delivery transformation models, workforce development strategies, health information technology (health IT) strategies, and population health strategies. Column 2 describes the federal and state levers that provide policy support for the SIM Initiative elements and shape the overall state context for this initiative. This context affects SIM implementation by tying reimbursement methodologies to quality measures, promoting integration of physical and behavioral health providers, expanding funding for health care education and workforce training and retention, promoting care coordinating technology, and developing the state's health IT workforce. The models and strategies in Column 1, supported by the policy levers in Column 2, are expected to affect outcomes described in the remaining columns.

As described in Column 3, the implementation process itself is assessed through general and state-specific process measures—which examine whether the SIM models and strategies have been implemented; and to what extent the state expects their implementation to increase the number of providers participating in value-based delivery models, expand the populations reached by such models, and affect a number of model-specific impacts, as detailed in Column 4. These changes are expected to produce further statewide changes, shown in Column 5, including improved quality of care and care coordination, lower health care costs, and overall improved population health, as assessed by both state and national health status measures.

J.3 Implementation Activities

This section discusses current health care system/issues in the state, its SIM strategies, and the existing infrastructure that will work with or alongside the SIM Initiative.

J.3.1 Context of health care system

Strengths and weaknesses of the Tennessee health care system

Tennessee is a geographically large state with significant diversity among its urban areas and large areas of rural communities. Health care delivery varies by region of the state, with large health systems and group practices covering the major metropolitan areas, and Federally Qualified Health Centers (FQHCs) and individual practitioners providing care in the rural areas, along with smaller hospitals. Health systems are continuing their geographic and vertical integration strategies that began before the SIM Initiative. Stakeholders repeatedly mentioned a highly rural population, aging private practices, and low Medicaid reimbursement rates as barriers to SIM implementation.

The state has identified significant health care needs among the population that experiences serious behavioral health issues. Historically, this target population has experienced a lack of access to physical health services, as well as coordination issues between primary care and behavioral health providers.

Medicaid. Tennessee did not expand Medicaid eligibility under the Affordable Care Act. Approximately 13 percent of the state’s population remain uninsured, and one provider stakeholder referenced lack of insurance as a major challenge facing the state.

TennCare has been fully managed care since 1994. Many stakeholders felt that this early adoption of managed care allowed the state to work through the associated complications and position itself as an experienced, progressive health care system. Multiple payer, provider, and consumer advocate stakeholders described challenges associated with the first decade of the TennCare program, however, which included high program director turnover, administrative difficulties, and reports of misuse of funds. The gubernatorial election of 2002, which was won by a health care professional with a background in managed care, marked a turning point in improving operations of the TennCare program, reducing both staff and administrative problems. Nevertheless, some stakeholders reported that feelings of distrust and skepticism among providers towards payers remain. For example, one stakeholder expressed that providers were skeptical of the EOC initiative, due to lingering distrust of TennCare that stemmed from the first decade of the managed care program. On the other hand, state officials reported that the last 10 years of strong managed care implementation had established trust between the providers and TennCare, which helped SIM implementation move forward.

Three managed care organizations (MCOs)—Blue Care, UnitedHealthcare, Amerigroup—provide the bulk of care, including behavioral health and long-term care, to the majority of TennCare enrollees. Tennessee contracts with its TennCare MCOs to provide behavioral health as well as physical health services, making it a “carve in” state. Multiple stakeholders described the MCOs as operating independent of one another in a noncollaborative manner, and said that one of the SIM Initiative’s greatest accomplishments to date was bringing

all three TennCare payers to the table. State officials indicate that the relationship between the MCOs and the state is very collaborative, which allows projects such as the SIM Initiative to succeed. To create alignment among the three MCOs, the state put the details of the delivery reforms into the MCO contracts.

Even though TennCare is fully managed care, many stakeholders, including the TennCare payers, characterized the payment structure as largely fee for service (FFS), in which providers are paid by the MCOs according to a fee schedule the MCO establishes. The state gives the money to the MCO, and the MCO establishes how it pays the provider. As such, there is no central fee schedule published by the state, as there is for states that operate FFS Medicaid programs. As a result, it is difficult to compare the Tennessee reimbursement rates to those of other states. However, several stakeholders expressed that Medicaid reimbursement rates were low in Tennessee.

Previous and concurrent health care transformation initiatives

Prior to the SIM Initiative, individual commercial payers and Medicaid MCOs had implemented PCMH pilots, but these did not become widespread. State officials said they believe the differences among the different health plan initiatives made it difficult for providers to fully engage. Also, state officials' assessment is that competitive pressures among MCOs preclude them from getting too far ahead of their peers in pushing reform initiatives. Consequently, in the words of one state official, the individual actions of the MCOs did not have the necessary "stickiness" to create statewide change. The SIM Initiative aims to implement a statewide PCMH program that is consistent across all three TennCare MCOs and that, eventually, is aligned with other payers.

SIM efforts run parallel to other primary care efforts, including Vanderbilt University's 2015 Transforming Clinical Practice Initiative grant from CMS and the Comprehensive Primary Care initiative also from CMS. Tennessee has yet to determine how to coordinate SIM implementation with these two other programs statewide.

Tennessee ranks 47th in the nation on the CMS Five Star Quality Reporting System for nursing homes. Tennessee's system includes 319 Medicare and Medicaid certified nursing facilities. Of these, 18 actively participate in the Advancing Excellence in America's Nursing Homes Campaign, according to information supplied by the state in its Operational Plan. This initiative provides free evidence-based resources and data collection tools designed to help nursing homes execute their quality assurance and performance improvement projects.

Prior to the SIM Initiative, the state began work on the Quality Improvement in Long-Term Services and Supports (QuILTSS) initiative, which is a VBP structure for long-term care. This work, which was made possible by a Robert Wood Johnson Foundation grant, began in 2013. Tennessee's three MCOs have managed the CHOICES program, which is a Managed Long-Term Services and Supports (MLTSS) program since 2010. Tennessee has operated three

Medicaid 1915(c) waivers for persons with I/DD. On July 1, 2016, Tennessee will implement a new Employment and Community First (ECF) CHOICES MLTSS program for persons with I/DD. The state also operates a small Programs of All-Inclusive Care for the Elderly program.

Summary

Across all stakeholder interviews, the RTI team heard a consistent refrain of the need for health system transformation in Tennessee to address the state’s relatively poor health status, and respect for the state’s decision to take on the SIM Initiative. Multiple stakeholders referenced the excitement they felt about seeing all health care players in the state come together for this new health system reform. This enthusiasm was tempered by some skepticism, however, particularly among provider organizations, around the specific strategies selected and the availability of resources to carry out system-wide change. Stakeholders believed that EOCs, PCMHs, and the CCT all had the potential to be successful, though stakeholders varied in which initiative they thought would be the most likely to bring lasting change—with no notable patterns among different stakeholder types. Overall, interviewees expressed support for initiatives that would increase transparency, collaboration, and communication among payers and providers, which many felt were lacking in the current health care system.

J.3.2 Governance and program administration

The Office of Strategic Planning and Innovation within the state Health Care Financing Administration (HCFA) provides day-to-day leadership and coordination for the SIM Operational Plan. The Director of the Office serves as SIM Project Director, and 10 staff within the Office are assigned to SIM work. The Director reports to the Deputy Commissioner of HCFA, who provides the senior leadership and direction.

Responsibility for implementation of specific SIM Initiatives is assigned to the appropriate units of state government, with all areas of HCFA deeply involved. The Long-Term Services and Supports Division implements both the LTSS payment and direct care workforce reforms within the SIM Operational Plan. Managed Care Operations, which includes the behavioral health team, is responsible for implementation of the Health Link behavioral health home initiative—as well as ensuring the MCOs perform their responsibilities for payment reform, care coordination, behavioral health, and primary care transformation. The Benefits Administration manages the inclusion of public employee health plans within the SIM Initiative, and the Department of Health is charged with developing the Population Health Improvement Plan for the SIM Initiative.

Tennessee supplements the state SIM staff with consultants. These help with the EOCs, CCT, primary care transformation, and workforce training. The state also contracts with the Tennessee Medical Association (TMA) to conduct outreach to physicians regarding EOCs and primary care transformation. Tennessee contracts with the Tennessee Chapter of the American Academy of Pediatrics (TCAAP) to assist physician offices to conduct quality improvement

projects. Five Schools of Public Health have been retained to develop regional population health improvement plans that form the basis of a statewide plan. Finally, the Medicaid MCOs and public employee health plans perform the data analyses to support implementation of approved EOCs and to conduct provider outreach. State officials report that the total of these resources is sufficient to implement and test the SIM Initiative.

Tennessee’s SIM Initiative affects multiple groups of stakeholders statewide, and the state has devised a diverse, intense, and multifaceted strategy to obtain their input. Tennessee reported having conducted 76 separate stakeholder meetings in first quarter 2016 alone. The strategy includes use of Technical Advisory Groups (TAGs) comprising payers, providers, and state staff; implementation and operations meetings with MCOs; and regular meetings with provider associations, community forums, presentations to external groups, monthly calls with providers, and implementation work groups with LTSS providers. State officials value their positive and collaborative relationship with other payers and with providers in the state. Therefore, they have made a commitment to listen to all input before finalizing SIM reforms and to work with partners to assure successful implementation (see *Stakeholder participation, Section J.3.3* for detail).

Interviewees largely agreed the state did a good job of soliciting diverse stakeholder feedback and being inclusive of multiple stakeholder perspectives. Many interviewees expressed their appreciation for the state’s leadership and accessibility, and for the overall vision of the TennCare team. Payers and providers generally felt their perspectives were heard, although not necessarily acted upon—with one provider characterizing this dynamic as “dialogue but not movement.” That is, even though stakeholders felt state officials were very open to hearing their concerns and opinions, some stakeholders perceived that the state had an a priori plan in mind that it would implement regardless. As one stakeholder reported, “It ... takes a point of pretty significant contention to get a modification in direction.” Even so, stakeholders acknowledged that the state needed to have a strong direction to implement an initiative of this size. Several providers highlighted the TAG process as a positive experience to engage with the state’s SIM team. Consumer advocates felt, however, that while the state did a good job engaging with provider and payer stakeholders, opportunities for consumer engagement were weak. These advocates did not feel the state had a plan for addressing the issue, because current as of June 2016, efforts remain largely health system– and health plan–focused.

J.3.3 Stakeholder participation

Provider organizations—including the Tennessee Hospital Association (THA), TMA, and TCAAP—are the primary stakeholders, along with the health plans, for the EOC, PCMH, and Health Link initiatives. Each of these organizations performs roles that go beyond traditional meeting participation and feedback. The TCAAP works with practices to design and implement quality improvement projects. The TMA conducts outreach to provider offices to teach them about the EOCs and PCMH. The THA performs data analytics to support its members in the

payment reform initiatives. Behavioral health providers and consumer groups are also important to the Health Link initiative. Nursing homes, community-based providers, and consumer advocates are the important stakeholders engaged in the LTSS models and strategies. Tennessee HCFA has long-standing relationships with each of these groups, and has worked with them on similar initiatives in the past.

Table J-1 outlines the SIM Initiative–specific stakeholder engagement strategies Tennessee is using to develop and implement specific SIM strategies.

Table J-1. Tennessee stakeholder engagement strategies

SIM Strategies	Technical advisory group	Community forums	Implementation work groups	Operations meetings
EOC	X			
Health Link	X			X
PCMH	X			X
LTSS		X	X	
Population Health Improvement Plan		X		

EOC = episode of care; LTSS = long-term services and supports; PCMH = patient-centered medical home; SIM = State Innovation Model; X = Engagement strategy used for SIM strategy.

The state’s LTSS team has sponsored 18 community forums in nine cities throughout the state to solicit input on development of the LTSS initiatives, with half targeted to providers and half to families. The state also uses work groups of providers in the implementation process. In addition, the Department of Health has sponsored community forums in nine cities throughout the state to inform development of the Population Health Improvement Plan.

In addition to the strategies outlined in Table J-1, HCFA conducts biweekly payer coalition meetings, monthly provider stakeholder calls, and presentations to community and stakeholder groups to share information and obtain feedback.

State officials emphasized the EOC TAG process and the improvements that have been made to it between Wave 1 and Wave 5, the development of which was completed in May 2016. These officials believe this process has become a best practice other states can emulate.

In the beginning, providers felt like they could not contribute as much to the TAG, because they did not know what was expected of them beforehand. The process has evolved so providers receive questions beforehand and the episode is explained twice—once in a webinar before the TAG meeting and once during the meeting. The process is very intense and requires significant commitments of state and stakeholder time. The Wave 5 experience was described by state officials as typical of the workload for all EOCs, with ten 3-hour meetings over 2 months. Prior to the meetings, consultants and HCFA staff developed base definitions for each episode in

the wave and five major recommendations regarding: (1) codes to trigger the episode, (2) who the quarterback for the episode should be, (3) what costs should be included, (4) risk adjustment, and (5) quality metrics. HCFA also obtained input from public health staff on each proposed episode prior to presenting it to the TAG. SIM state officials are committed to keeping the initiative on track and report that improvements to the TAG process have allowed an efficient process with meaningful input to keep the state on track to implement six to eight episodes every 6 months.

PCMH TAG members, consisting of clinical experts throughout the state, have developed recommendations around quality metrics, provider training and supports, patient engagement, requirements for PCMH practices, and best clinical practices. Additionally, the Health Link TAG made recommendations on the design of the Health Link model and associated quality metrics.

The majority of stakeholders said the state reached out to engage them during the initial planning period for the SIM award. And several organizations said that they had been in conversation with the state about the SIM Initiative prior to the award application. Stakeholders have participated in the SIM process at more than 575 meetings since February 2013, and continue to be involved through regular participation in work groups and committees, attendance on bi-weekly payer calls and monthly provider calls, and attendance at in-person TAG meetings for the EOCs, PCMHs, and Health Link. Provider groups such as the TMA and the Tennessee Primary Care Association were asked to submit names of suggested providers for participation in the TAGs. Several stakeholders also mentioned arranging personal meetings or calls with the state implementation team.

Certain challenges to stakeholder engagement were heard repeatedly across stakeholder groups. Payers, provider groups, and consumer advocates all expressed that holding all TAG meetings in Nashville, with no financial reimbursement for attendance, prevented many nonlocal providers from attending. This was especially true for those in rural areas and smaller practices, who were unable to take several uncompensated days off work to attend the multiday meetings. Stakeholders voiced concern that the TAGs, therefore, represented a limited sample of central Tennessee providers, and suggested that phone or videoconferencing would have allowed wider participation. Many stakeholders felt the state did a good job of bringing varied stakeholders to the table and giving them a platform. But, as noted in **Section J.3.2**, stakeholders felt that their feedback was often not acted upon (because the state was perceived to have had a clear program model in mind from the beginning), and consumer stakeholder groups described little opportunity for consumer participation (attributed partly to the challenges inherent in adequately educating consumers about the initiative so they can become involved). Finally, some payer and provider stakeholders emphasized the importance—and challenge—of engaging providers in the SIM Initiative, and suggested that more work should be done by the state to emphasize the financial benefits to providers of participation.

J.3.4 Delivery systems and payment reforms

The Tennessee SIM Initiative's three overarching strategies include five major payment and delivery reform initiatives: EOC payments for specialty care, PCMHs, health homes (Health Link), a statewide CCT, and LTSS payment reform.

EOC payments encompass all care delivered by multiple providers around a specific clinical situation with a designated start and end date. The state is planning to implement six to eight new EOCs every 6 months, with the goal of having implemented 75 episodes by fourth quarter 2019. Payers participating in the initiative will hold one key provider—the principal accountable provider (PAP)—accountable for overall cost and quality of the episode. The PAP will receive quarterly reports from payers showing performance data on costs and quality, including number of episodes, average risk-adjusted episode cost, and quality metric results. For every episode, as noted, a TAG of clinical experts determines the most appropriate PAP for a designated episode, the specific health care services to be included in the episode, and appropriate quality measures and sources of value. The underlying payment structure continues to be FFS. While all providers are part of the EOC reporting, only the highest cost 10 percent of providers will have funds taken away and the lowest cost 25-50 percent will receive bonuses.

The PCMH model will align PCMH efforts by the TennCare payers in Tennessee under a unified program that aims to increase high-quality, cost-effective primary care. All three TennCare MCOs currently have a medical home program, but these are separate programs with differing criteria and incentives. Under the SIM Initiative, a statewide joint PCMH program is scheduled to begin in all three TennCare MCOs in January 2017, with approximately 25 practices, and quality metrics will be used to link payment to value. Large practices (those with more than 5,000 members) will be evaluated for shared savings on total cost of care; small panel providers will have their efficiency metrics performance translated into implied savings based on utilization. The three TennCare MCOs are mandated to participate in the unified PCMH program. For most of the TennCare payers the RTI team spoke with, the SIM PCMH program will run parallel to their existing programs, rather than replace them. Ultimately, the goal of the SIM PCMH strategy is to build up to a statewide aligned commercial and Medicaid PCMH program. However, all the TennCare payer interviewees expressed skepticism on whether the TennCare PCMH program will be sustainable in a commercial population without altering the program to better fit that population. Specifically, payers were concerned that the care management fees and gain-sharing payments associated with the SIM PCMH initiative will not translate to the commercially insured population without major adjustments. Hospitals that are mandated to participate in the PCMH program for TennCare beneficiaries may not elect to participate for their commercially insured populations unless they see a potential financial benefit.

Health Link will launch in fourth quarter 2016. Tennessee will leverage the enhanced federal match to offer prospective payments for care coordination and case management for

participating providers for 2 years—as well as SIM-supported training and capacity building, and quarterly cost and quality reporting. Health Link providers will receive prospective payments for care coordination and case management services, and starting in the second year, top performing practices will be eligible for bonus payments tied to process and outcome measures of quality and utilization. Health Link’s focus on integrating physical and behavioral care builds upon existing efforts at FQHCs and community mental health centers in the state. In 2007, TennCare sought to encourage an integrated approach by combining physical and behavioral health administration within every MCO. With Health Link, the state is moving all targeted case management activity under the health home umbrella and expanding the scope of services provided. Behavioral health case managers will no longer have to make face-to-face encounters to be paid, and can be paid for getting their clients’ physical health needs addressed.

The CCT will allow both primary care practices and behavioral health providers (participating in PCMHs and Health Link, respectively) to receive ADT feeds from hospitals and emergency rooms (ERs). The aim of this tool is to allow providers to better manage their patient populations by tracking hospital stays, prioritizing activities by patient risk score, and identifying gaps in care. Implementation of this state-hosted electronic CCT is proceeding on schedule. Prior to the SIM Initiative, one of the TennCare health plans had implemented such a tool, and the state decided this was an important initiative to implement statewide and across payers. Tennessee has selected the Altruista Guiding Care software platform as the CCT.

LTSS payment reform under the SIM Initiative includes several approaches to improving quality and promoting value-based purchasing—including for nursing facility and HCBS services for older adults and those with physical disabilities, and individuals with I/DDs. These approaches fall under the QuILTSS initiative and broader system redesign efforts. QuILTSS, a TennCare value-based purchasing initiative, started in late 2013 to promote meaningful LTSS quality measures. Under this initiative, nursing facilities receive retrospective adjustments to their per diem rates based on that facility’s patient population acuity and performance on quality metrics. The state expects to transition to prospective adjustment of the facility rates based on historical data at the beginning of 2017. In addition, the state will shift away from a per diem reimbursement structure for Enhanced Respiratory Care services to VBPs that incentivize liberating patients from a ventilator. The VBPs rolled out in 2016. Tennessee is also developing the LTSS workforce by developing a registry of direct care workers along with a curriculum that aligns with direct care worker core competencies. The workforce component is well under way; the state has held meetings all over the state and is working on curriculum development and roll-out.

Tennessee’s delivery system and payment reforms can be characterized as both broad and deep. Each initiative is being implemented statewide, and all except Health Link are expected to be implemented eventually across all payers (TennCare, public employee, Medicare, and commercial plans). Furthermore, these initiatives foster change in primary and specialty care,

behavioral health, and LTSS. To achieve this breadth, Tennessee has focused on stating the case for change and creating consensus on the vision for delivery and payment reform, while allowing flexibility in implementation by health plans and providers. For example, commercial payers may choose not to implement some EOCs because they have less relevance to their covered population than is true in TennCare. Also, the specifics of the PCMH payment structures may vary among commercial payers once the PCMH model spreads to the commercial sector. One state official described this process as “setting the boundaries of the playground and letting the health plans fill it in.” The state has focused on a strong vision, which a state official characterized as “making sure the choice is between one VBP versus another. No one stays in fee for service.”

The SIM Initiative envisions a continuum of involvement with health plans. The state exercises the most control and oversight of the SIM Initiative within the TennCare MCOs, somewhat less with Medicare Advantage and Medicare Dual Eligible Special Need Plans, and the least with commercial carriers. This continuum also reflects the flexibility inherent within the strategies. Although the state wants to see consistency across payers, it recognizes that TennCare enrollees, state and other public employees, and other commercial populations are different from one another. Even so, one consumer advocate expressed that there is less flexibility to modify the episodes for the commercial population than preferable. The two health plans that cover public employees are doing EOCs, but the public employee plans are not implementing behavioral health episodes because they carve these services out. Cigna uses Prometheus and will continue to use that methodology rather than the one developed under the SIM Initiative. Also, the public employee plans will require a provider to have 40 patients in an episode before the value payment will apply—in contrast to TennCare, in which any provider with at least one patient in an episode is included.

Payers were somewhat supportive of the new payment mechanisms, acknowledging that the aims of the measures were generally in line with their own initiatives. Payers expressed concern around the aggressive implementation schedule for 75 EOCs, however, and wondered if the number of episodes could have been reduced by focusing only on episodes with high volume and great price variability. Payers also suggested the episode waves could have been better coordinated, so that all behavioral health episodes were implemented at the same time. In addition to these payers’ concerns, one provider organization described the EOC design as inherently flawed, because in Tennessee’s managed care environment, “variation in costs show variations in negotiated rates” (rather than variations in utilization). Providers were also concerned about the lack of standard risk-adjustment methodologies across payers. Overall, payers questioned the impact this payment mechanism will have on changing behaviors among providers, especially those in larger health systems for which costs are less of a concern. One MCO said that 63 percent of its providers are opening the EOC quarterly reports, and while smaller practices may be more sensitive to reimbursement variations, larger systems may prefer to “write a check rather than engaging with the analysis.” To help providers understand and act

on the EOC quarterly reports, one MCO hired regional practice performance managers who educate providers on how to download and read the reports. The MCO received positive feedback on these managers from both providers and the state; however, that MCO stated that it is not a sustainable program for 75 episodes.

Tennessee adjusted its timing for implementation of some of the initiatives. The EOC program has been the first to be implemented and is proceeding according to schedule. Five waves of development have occurred and reports for episodes in Waves 1 and 2 have been distributed to TennCare providers. The first bonus payments and bills for paybacks were issued in August, 2016. The commercial plans that administer the public employee health plans will distribute Wave 1 and Wave 2 reports to providers January 1, 2017. The state has adjusted its expectations for the timing of payment reform by payers other than TennCare, however. Originally, the state planned to have all product lines launch their payment reforms on a concurrent timetable. As implementation discussions began, they determined that this was too aggressive. The current expectation is that TennCare implements first, followed by the public employee health plans. The TennCare MCOs and commercial payers that manage public employee health plans are expected to implement EOCs in their other commercial markets as well, so commercial and Medicare Advantage plans will be reached as the payers expand episodes to their other markets.

PCMH and Health Link were both scheduled to be implemented on October 1, 2016, but the state decided this schedule would be problematic for providers and has delayed PCMH until January 1, 2017. To allow more time for providers to prepare, Health Link implementation was pushed back by a couple of months to December 1, 2016. One state official described implementing Health Link as “changing the payment structure overnight,” indicating that the payment structure changes under Health Link will have a significant and immediate impact on both providers and payers upon implementation. This official further explained that, for some providers in the state, the Health Link population is a significant portion of their budget and therefore these changes will have an even larger effect on them.

QuILTSS is proceeding on schedule. It is currently seven cycles into the receipt of quality data from nursing homes, and seven cycles into retrospective adjustment of individual facility payments based on their quality scores. State officials report that this is having a positive impact, with facility performance improving on person-centered assessments and measuring patient satisfaction. The state will be implementing prospective rate adjustment for nursing homes on January 1, 2017. QuILTSS is moving much more slowly in the CHOICES waiver program—due to the diversity and number of providers, along with less data infrastructure to collect and report the quality measures the state seeks. The state’s SIM Initiative anticipates that this segment will begin in 2017. Value-based payment for extended respiratory care providers began July 1, 2016 as planned, and is structured as a bonus to the per diem based on quality metrics.

Tennessee is also proceeding on schedule with implementation of two additional delivery system reforms for persons with I/DD. First, in January 2016, the state began implementation of a behavioral health crisis intervention and stabilization model. The payment structure consists of a monthly case rate that is front loaded and reduces over time, and the state plans to build in payment changes based on quality metrics over time. Second, on July 1, 2016 under a Medicaid 1915(c) waiver, the state implemented the ECF CHOICES managed LTSS program for persons with I/DD.

J.3.5 Health information technology and data infrastructure

Tennessee does not have a statewide health information exchange. Interviewees generally described the existing health IT infrastructure in Tennessee as limited and fragmented. Two regional health information organizations exist, one in Knoxville and one in Memphis. However, providers described the process of accessing data through those, as well as getting permissions from both patients and other providers, as prohibitively burdensome.

The state has an all-payer claims database (APCD), but this does not include any data from self-insured claims and has significant data limitations. Stakeholders expressed that these data are not made available to provider organizations. Said one provider, “We tried to get access to the data in this legislative session and the state said they’re not ready to share data with us.” Multiple stakeholders also cited the recent Supreme Court decision⁹¹ that self-insured employers could not be required to submit data for the Vermont APCD as contributing to the Tennessee’s reluctance to share the data. State officials also noted that the APCD lacks a public presence because not many people have had the chance to use it.

Under the SIM Initiative, the state is focused on developing electronic health information applications useful to TennCare providers, payers, and the state. Specifically, the state is focused on implementation of the CCT, development of quality metrics and reporting based on clinical data, and development of a single provider-facing portal for TennCare providers, through which all data can be exchanged. Tennessee is leveraging SIM funds—along with Medicaid Management Information System, Health Information Technology for Economic and Clinical Health, and other funding sources—to achieve its health IT goals. However, stakeholders were generally unaware of any state efforts to incentivize use of health IT, beyond Medicaid Meaningful Use. Several provider stakeholders expressed that establishing strong IT infrastructure requires both money and capacity, and some practices—particularly older providers and smaller practices—may not be able to do so, due to resource constraints in hiring data staff and equipment or to an unwillingness to adopt new strategies.

The contract for Altruista and its Guiding Care software as vendor for the CCT began March 1, 2016, and initial implementation calls for piloting the tool in 10 practices for 8 weeks began in summer 2016. ADT forms from all Tennessee hospitals, claims data from the TennCare

⁹¹ Gobeille v. Liberty Mutual Insurance Company, 136 S. Ct. 936 (2016)

MCOs, pharmacy data from the TennCare Pharmacy Benefits Manager, and attribution data from the MCOs will be fed into the tool. Altruista will then apply its care management algorithms to produce alerts, gaps in care analyses, patient risk scores, and polypharmacy reports. These analyses will be shared with the attributed PCP and the Health Link case managers for follow-up. The state has reported one challenge, relating to PCP attribution. Each MCO stores and uses data differently; mapping data from the different MCOs to the Altruista tool in a way that assures consistency has proved difficult. The state, Altruista, and the TennCare MCOs have been meeting to develop a solution.

The second health IT strategy of the Tennessee SIM Initiative involves development of quality metrics; these are calculated using available clinical data, rather than relying solely on claims data. For example, data may be pulled from existing registries, provider electronic health records (EHRs), or patient self-reported data to populate the measures. The goal is to make clinical quality data available to payers and providers to support the VBP mechanisms such as EOC and QuILTSS. Tennessee expects to issue a request for proposal in fall 2016 to select a vendor to complete the quality metric development work.

Finally, Tennessee is developing a single statewide portal for TennCare providers to submit and receive required electronic health information. This will include information from the CCT, the quality metric applications, and the reporting MCOs will send to providers to support the EOC and PCMH pay-for-value programs. The provider portal is a TennCare initiative; neither the public employee health plans nor any other payer will implement the provider portal as of June 2016. SIM staff did indicate that, as host for the CCT, the state will give other payers the option of using it.

As of the June 2016 site visit, the LTSS activities were not incorporated into either the CCT or the quality metric applications, but the state hoped they will be in the future. State staff within the LTSS Division collect, analyze, and report on the quality measures for their programs.

J.3.6 Workforce development

Tennessee's SIM Initiative contains four components related to health care workforce development:

- ***Training for behavioral health workers on the Health Link model.*** The state has contracted with a vendor to conduct the training and to support a learning collaborative. Training begins summer 2016 and continues after the October 1 2016 implementation date.
- ***Training for primary care practices on practice transformation, primarily care coordination processes.*** Again, the state is using a vendor to conduct the training and to support a learning collaborative. The Tennessee Primary Care Association effort to support quality improvement projects and activities within pediatrician offices can

also be considered a workforce development effort, in that they are increasing the skills of the practices to do this work.

- ***Development of registry for credentialed direct care workers for long-term services and supports.*** The vendor has been selected for this work and development is under way.
- ***Development of a curriculum for the education of direct care workers for long-term services and supports.*** The goal for this curriculum is to offer portable, stackable credentials and college credit toward a certificate or degree program. The state intends to deploy this curriculum through secondary, trade, and vocational technical schools, along with community and 4-year colleges. State officials recently completed a series of community forums to provide input, and now have 200 volunteers who will participate in development of the curriculum.

Several provider stakeholders acknowledged a shortage of providers, especially PCPs, in the rural regions of Tennessee. In focus groups, both Medicaid beneficiaries and providers discussed the great difficulty in getting appointments with providers that accept TennCare—especially among such specialties as rheumatology, orthopedics, pain management, and pediatric behavioral health.

SIM efforts will run parallel to a variety of existing health care workforce initiatives in Tennessee:

- ***Recruitment and retention.*** The Tennessee Rural Partnership is a nonprofit, operating subsidiary of the THA that administers residency stipends for providers who work in rural areas of Tennessee and operates training programs for medical students and residents in rural, underserved care settings. The Tennessee State Loan Repayment Program, administered by the Office of Rural Health, provides loan repayment up to \$100,000 for providers working in underserved areas. The Tennessee Regional Extension Center (tnREC) helps to match health IT professionals with available positions across the state.
- ***Training.*** The tnREC has developed an Educational Technology Advisory Committee that develops health IT curricula for educational institutions in the state, as well as a statewide health IT workforce development plan.
- ***Regulation.*** Tennessee law allows nurse practitioners (NPs) to diagnose, treat, and refer patients relatively independently, and prescribe drugs under a supervising physician (after establishing a collaborative practice agreement). The NP is not required to practice at the same location as the supervising physician, but the physician must be available for consultation at all times and must review 20 percent of the NP's charts each month. Although not a part of SIM, the scope of practice for primary care NPs is an ongoing conversation in Tennessee and stakeholders have differing views on the issue. One physician stakeholder expressed significant concern about this direction: "I think it's a mistake policy-wise ... to be an NP in this state, the clinical expectations are low." However, he acknowledged that expanded scope of

practice for NPs may be the only affordable short-term solution to meeting the state's primary care needs.

J.3.7 Population health

Tennessee's population health plan was still in development during the May 2016 site visit. The population health component of the state's SIM Initiative is a coordinated effort between the Department of Health and TennCare; the Department of Health has sole ownership over development of the population health plan. A state official noted that the health commissioner is supportive of the SIM Initiative's population health efforts, and the "ultimate goal is to nudge our health system and our society upstream." In pursuit of that goal, the Department of Health took advantage of the SIM Initiative to expand its partner outreach and do a more extensive overhaul of its annual update to the population health plan—partnering with five university public health programs across the state, and holding nine meetings (one in each congressional district) to aid in development of a comprehensive health plan to address the public health problems facing Tennessee. The goal is to create a state-level framework for population health programs that can be individualized and adapted at the local level through an interactive website. Such a website will house a matrix of options that allow stakeholders to choose a public health topic, like tobacco use, and have access to policies, programs, and best practices for implementation in a variety of settings, such as education and faith-based organizations. This approach will help align initiatives with the Department of Health's three overarching criteria for state population health programs: (1) moving the focus upstream, (2) learning from and teaching others, and (3) focusing on health outcomes. Outcomes will be measured using a set of "Tennessee vital signs" (based on National Academy of Medicine vital signs) that would serve as a measure of accountability. The Department of Health's thought is that a less academic and more interactive approach to the population health plan will better reach diverse populations interested in engaging in public health.

Population health perspectives are also integrated into the payment reform and delivery system of the SIM Initiative through the Department of Health's representatives on the TAGs for the EOCs, PCMHs, and Health Link. For the EOC TAG, population health representatives provided predecisional feedback for consideration in each episode's design before presentation at TAG meetings.

J.3.8 Technical assistance and other support resources

Tennessee state officials report that CMMI project officers and staff are very good and that the CMS vendors are "great...prompt, interested in helping." The one area of concern expressed by the state is the CMS grants-management approach to the SIM Initiative. These officials believed the individual year award is very difficult to manage in a large innovation project, because initiatives move at different paces and often vary from the original plan. They said they wanted to be able to move forward when stakeholders are ready, yet they perceive the

grants administration process often precludes this, in large part because CMS seems to respond to state requests slowly.

J.3.9 Progress, challenges, and lessons

Tennessee state officials said they are pleased with the progress they are making. As of the 2016 site visit, the first wave of EOCs has been implemented, recruitment for PCMH providers has begun, and the Population Health Improvement Plan is in development. As one official stated, “Everyone has agreed to align on quality.” The state said it has perfected the EOC TAG process through the five waves of development, and that this has really become a best practice for others to emulate. While still early in the process, initial indications from the state’s data at the time of the 2016 site visit were that average quality is improving and average costs are decreasing. State officials were also very satisfied with implementation to date of the CCT. Within LTSS, they believed they have developed several pay-for-value and quality reporting pieces that are foundations for the SIM Initiative to build on.

Many stakeholders reiterated that the SIM Initiative is still in its early phases in Tennessee, and much remains to be seen regarding implementation and impact. Stakeholders remain engaged in the SIM process through regular work group calls and TAGs.

The process has also revealed multiple challenges from the perspective of the state and other stakeholders:

- **Resource strain.** Several state officials said they had underestimated how much work the SIM Initiative really is and that states need to understand that this is a full-time job for everyone involved. Provider and payer stakeholders repeatedly expressed that implementation of the SIM Initiative has created a significant strain on internal resources. This includes the time needed to: (1) attend stakeholder meetings and TAGs; (2) develop internal systems for EOCs, PCMHs, and Health Link; (3) interpret data reports; and (4) provide education and training to providers (when applicable). One payer stakeholder said that he is in meetings with the state for half a day every week, and time is not used efficiently during the meetings. This same payer explained that his organization has hired more than eight additional employees to assist with implementation, its annual spend is \$3.5 million unfunded, and this spending is not seen as sustainable moving forward. Some providers expressed concern that the SIM Initiative presented yet another set of requirements on top of recent regulations like the ICD-10 shift and the Medicare Access & CHIP Reauthorization Act of 2015. Although interviewees’ answers varied greatly when asked about resources at the state level, several expressed concerns about the state’s ability to effectively implement and test the SIM Initiative.
- **Timeline and scope.** Nearly every stakeholder interviewed expressed concern over the aggressive timeline of the SIM Initiative. Stated one payer, “I would not do all of this at the same time. It is a lot of change with the same people managing all of that change, and it is kind of overwhelming.” At several of the payer organizations, a small group of individuals was described as managing implementation of multiple

simultaneous SIM reform initiatives. Payers and providers also felt that the timeline for implementing the various SIM components could have been more spread out to ease the internal burden. Some payers noted that the large scope of the PCMH strategy can cause problems, because any small issue in data systems or reporting will be amplified many times over.

- ***Provider engagement and communication.*** The SIM Initiative touches several types of providers across the state, as well as each provider within those types. One state official indicated that engaging the providers requires a phone call or face-to-face visit with each provider to explain what is changing and why. This requires extensive and frequent communication using several modalities. During provider focus groups, however, awareness of the SIM Initiative was very low among both PCPs and obstetrics/gynecology providers. Provider stakeholders echoed the need for more robust education among providers and hospital systems around the forthcoming changes. One stakeholder stated, “I have not yet talked to a CEO [chief executive officer] of a hospital who knows that his ER is responsible for an asthma episode starting in 2016. That means nobody is setting up the necessary systems.” Although payers and provider organizations have trained advocates to speak with providers and educate them about the SIM Initiative, many felt that providers do not have sufficient time to engage with these advocates. Further, the RTI team heard from multiple stakeholders that providers remain skeptical of the SIM strategies. Hospitals were reported to be particularly negative towards the EOCs.
- ***Health information technology and data analytics capabilities.*** Provider, payer, and consumer advocate stakeholders all expressed concern about the health IT and data analytics capabilities providers will need to participate in the SIM Initiative. Although stakeholders agreed on the great need for increased data transparency and care coordination in the state, many felt that the state’s data reports will not be actionable unless providers have the knowledge and resources to interpret them. This will be even more of a challenge for small practices and private practices that may lack the ability to train/hire data analysts.
- ***Medicare and commercial buy-in.*** Payers felt that the SIM Initiative will not be sustainable by focusing solely on the Medicaid population. Said one, “If it’s hitting commercial, Medicare, military, etc., everyone is marching in the same direction.” As of the 2016 site visit, Medicare was not participating in the Tennessee SIM Initiative.
- ***Statewide health landscape.*** The SIM Initiative takes place within the broader health landscape of Tennessee, which includes high levels of obesity, hypertension, and tobacco and opioid use; as well as significant poverty, lack of insurance, and limited educational attainment. One consumer advocate noted that improving population health will require interventions at multiple levels, not only on a health systems level, and that the SIM Initiative should be considered only one piece of a multidimensional plan.

Although Tennessee is still early in the process of implementation, a few lessons learned have emerged:

- ***Trying to do multi-payer reform implementation all at once is too much.*** As a result, the state modified their vision of when different payers will come online with the reforms.
- ***It is important to give payers flexibility in how they achieve the goal, because commercial payers operate in a very different environment than public payers.*** For example, health plans are often third-party administrators for self-insured employers, and state officials said there are potentially limits about how far these groups can be asked to go with particular reforms.
- ***State-led health reform can be an effect modifier for other health reform efforts within a state.*** A consumer advocate reflected that the SIM Initiative has already served as an effect modifier within Tennessee—by serving as a catalyst for Vanderbilt’s 4-year, \$28 million Transforming Clinical Practice Initiative grant from CMS, as well as care coordination efforts in Memphis. “I don’t think any of this would have happened without the SIM grant,” she explained.

J.4 Statewide Changes

This section discusses stakeholders’ perspectives regarding what elements of the SIM Initiative are expected to impact desired outcomes and their beliefs about the potential impact of these elements.

J.4.1 Health care expenditures

One of the primary aims of Tennessee’s SIM Initiative is to bend the cost curve by shifting from paying for volume to paying for value in each of its three primary models. By paying for value in EOCs, primary care transformation, and LTSS payment reform, the state aims to reduce expenditures while improving quality of care and population health.

As noted above, although TennCare is fully managed care, the payment system is characterized as FFS by payers, providers, and other stakeholders. Stakeholders were optimistic that the SIM Initiative would accelerate a “much needed” move to VBP in the state; however, stakeholders had mixed views on whether the three SIM Initiatives would be enough to change health care expenditures in Tennessee. While the state and some stakeholders thought EOCs showed promise to effect change by putting the responsibility on the provider most in charge, others felt that the EOC reports were too dense for providers to glean any meaningful information from them to change behavior. Multiple stakeholders agreed, as noted, that large providers would rather write a check than spend the resources to make the data actionable and change behavior.

Likewise, the state and some provider groups were optimistic that the PCMH focus on improving care coordination will ultimately bring health care expenditures down. However,

other stakeholders questioned the readiness of providers in the state to make the practice transformations necessary to see meaningful change.

Most stakeholders agreed that it will take time to observe changes in health care expenditures, but the state and other stakeholders were optimistic that changing to VBP through the three overarching SIM strategies will contain costs over time.

J.4.2 Health care utilization

The EOC, PCMH, and Health Link models are intended to improve care coordination and quality of primary care, as well as specialty care—by reducing unnecessary care utilization. Both provider and consumer focus groups indicated that before the SIM Initiative, many Tennessee Medicaid beneficiaries used the ER on a regular basis. Although the vast majority of consumer focus group participants had a PCP, they indicated that they still visit the ER when they cannot get an appointment with their doctor—which they said is often, as they have many difficulties obtaining appointments. But focus group providers said it is very difficult to keep patients from visiting the ER for nonemergencies, irrespective of appointment availability—emphasizing that keeping patients out of the ER requires a significant time investment to build the relationship and trust to convince the patient to wait to see a provider in a clinic. Both providers and consumers indicated that changing ER visit patterns will require a significant change among Medicaid beneficiaries.

The state expects the improved care management through the SIM PCMH and Health Link programs to help facilitate the shift necessary to reduce unnecessary ER use and avoidable inpatient admissions. With improved care coordination and follow-up visits, the state expects 30-day readmissions following an inpatient visit to decline as well. The CCT was also expected to help in notifying providers of any visits to the ER or hospital; the providers can then follow-up with patients to prevent future avoidable utilization. As providers are communicating more with patients, the increased communication is expected to help build the relationship that the focus group participants indicated is required to produce the necessary cultural change for reform to be effective.

J.4.3 Care coordination

Care coordination is one of Tennessee’s primary strategies to achieve the goal of reducing costs while improving patient care. Provider stakeholders, consumers, and state officials all indicated that the state has room for improvement in care coordination. Provider organizations described care coordination as “disjointed” and “hit-or-miss”; stakeholders felt care coordination is being done well only in limited areas (such as Memphis community health centers and academic medical centers), or for limited groups of patients (such as high-risk individuals).

Consumers expressed mixed opinions on how well their care is coordinated. While some consumers indicated that their PCP communicates with their specialists, others said there is no coordination of their care between their PCP and other providers. The majority of consumers said they find it difficult to get an appointment with specialists, though some indicated that their PCP facilitates obtaining quicker appointments if their needs are urgent. Some focus group consumers said their PCP has no way of knowing about any visits to the ER or hospital unless they inform the provider themselves, but others indicated their PCP receives automated notices of any visits.

Likewise, providers expressed varying use of CCTs in their practices. Some providers had EHR systems in place and tools to receive automated notices of any hospital visits by their patients. Other providers said they have not adopted EHR systems and have no plans to do so. While many providers had after-hours call lines and evening and weekend appointment slots, some providers said they are only available to patients during regular clinic hours. Similar to consumers, the PCPs expressed frustration about the inability to obtain appointments with specialists for their patients. The variation the RTI team heard during the focus groups is in line with the stakeholders' view already quoted that care coordination is "hit-or-miss" in the state.

EOCs, PCMHs, health homes, and the CCT were all designed to improve care coordination. The state and other stakeholders who designed EOCs believe that EOCs should improve care coordination by making the PAP accountable. Because the PAP for an episode is often a specialist, PAP accountability incentivizes the specialist to better coordinate the care for the episode across all providers. By design, PCMH providers are supposed to better coordinate care by proactively learning about their patients' visits to hospitals or ERs and following up with patients afterwards. In addition, PCMH providers are supposed to coordinate care with community partners. Health homes aim to better integrate and coordinate behavioral health and primary care. The CCT is to enable PCMH and health homes to track hospital stays and ER visits, prioritize activities by patient risk score, and identify gaps in care.

Stakeholders, including the PCMH TAG, gave a few ideas on what successful care coordination would look like: (1) providers would consistently obtain discharge summaries from the hospital and know who had visited the ER; (2) providers would proactively identify patients with unplanned inpatient admissions or ER visits; (3) providers would proactively contact patients for follow-up after an admission or ER visit; (4) data would be available in an electronic format so providers could make informed decisions on patient care; and (5) providers would have the full picture of a patient's care, including care provided by specialty and other providers. To be designated as a PCMH, practices are required to incorporate all these activities into their practice. The rates of unplanned ER and inpatient admissions will be tracked by Tennessee as outcomes for PCMHs.

Some PCP stakeholders and the state expressed optimism about the potential for the EOC and primary care transformation initiatives to improve care coordination. Many payers and

providers cited the primary care transformation pieces—including PCMHs, health homes, and the CCT—as critical in improving care coordination over time. One provider described the CCT as “something we desperately need” and PCMHs as “an extremely important initiative” that will streamline and standardize the many existing payer-run PCMH programs and improve the coordination of care across providers. Other stakeholders were more skeptical about the potential for improvement, because of the required behavioral change on the part of providers and patients.

J.4.4 Quality of care

Focus group consumers were mixed in describing their levels of patient satisfaction in pre-SIM years. More expressed negative views of providers, although some consumers said they are satisfied with their pre-SIM care. The majority of consumers with positive experiences indicated their providers know them well and are concerned about their health. The most common criticisms among those who had negative experiences were that wait times for appointments are unnecessarily long, time actually spent with providers is limited, it is difficult to make an appointment, and they often see different providers when visiting their primary care clinics. Consumers reported having wait times of 1 to 2 hours and noted that non-Medicaid patients do not experience the same wait times. An additional primary complaint among consumers, which impacts their quality of care, is the exorbitant cost of prescription drugs. Several consumers reported spending hundreds of dollars each month on prescriptions, and indicated they cannot always fill all their prescriptions due to the cost.⁹²

The state expects primary care transformation to improve the quality of primary care consumers receive. The PCMH TAG recommended 15 quality metrics that would tie VBPs to quality, including both adult (e.g., antidepressant medication management, statin therapy for patients with cardiovascular disease) and pediatric (e.g., attention deficit hyperactivity disorder follow-up care, asthma medication management) measures. The PCMH’s progress on these metrics will be tracked by the state, and every three months the state will provide practices with a performance report that shows their performance on the metrics (relative to previous performance, the performance of peer organizations, and national benchmarks).

In addition, the quality of care for selected medical episodes should improve by providing PAPs with actionable data and measuring quality around the episode. The state reports measurable quality improvements for the first round of episodes, and the state will continue to monitor improvements for those episodes as each wave is launched. The quality metrics are specific to the episode (e.g., the quality metrics for the perinatal episode include the percent of

⁹² The high cost of prescription drugs for some adult beneficiaries in Tennessee may be due to a five-prescription limit per month on prescription drugs and refills that TennCare implemented in 2005 for adult beneficiaries not receiving nursing or other long-term care. With some exceptions, of these five, only two brand names drugs are covered. This limit does not apply to all drugs, and this limit does not apply to drugs that a prescriber attests meet an urgent need.

episodes with screening for HIV and the percent of episodes where the patient undergoes a Caesarean section).

The Health Link TAG recommended five behavioral health quality measures and five physical health quality measures. Starting in Year 2, Health Link practices will be eligible for bonus payments based on their performance on these outcomes. The behavioral health measures include follow-up after hospitalization for mental illness within 7 and 30 days, and initiation/engagement of alcohol and drug dependence treatment. The physical health measures include comprehensive diabetes care and asthma medication management.

Finally, the state expects the quality of long-term care to improve with the shift to value-based purchasing for LTSS. In particular, the state expects patient satisfaction, person-centered care, and quality of life to improve with the QuILTSS initiative. As nursing facilities are better equipped to measure patient satisfaction and receive prospective payments based on their quality measurements, the state expects that facilities will act on the data gathered to improve patient experience. Further, the state expects that respiratory care VBPs that shift towards incentivizing liberating patients from ventilators will improve patient satisfaction and quality of life.

J.4.5 Population health

As noted, the state's SIM population health plan was still in development during the May 2016 site visit. The goals of the population health plan include moving the process upstream and focusing on health outcomes. As noted previously, outcomes will be measured using a set of "Tennessee vital signs" (based on National Academy of Medicine vital signs) as a measure of accountability. The vital signs include a wide array of outcomes, including obesity, life expectancy, care access, well-being, and healthy communities.

The designs of the EOCs, PCMHs, and Health Link also integrate population health perspectives. The PCMH TAG has recommended quality metrics related to the population health outcomes, such as adult body mass index screening and childhood immunizations. For the EOC TAG, population health representatives provided predecisional feedback for consideration in each episode's design, before presentation at TAG meetings.

Although some stakeholders noted that population health could improve over time with better care coordination through the PCMH and health home programs, most did not yet have a view on how the SIM Initiative might impact the overall population health of Tennessee.

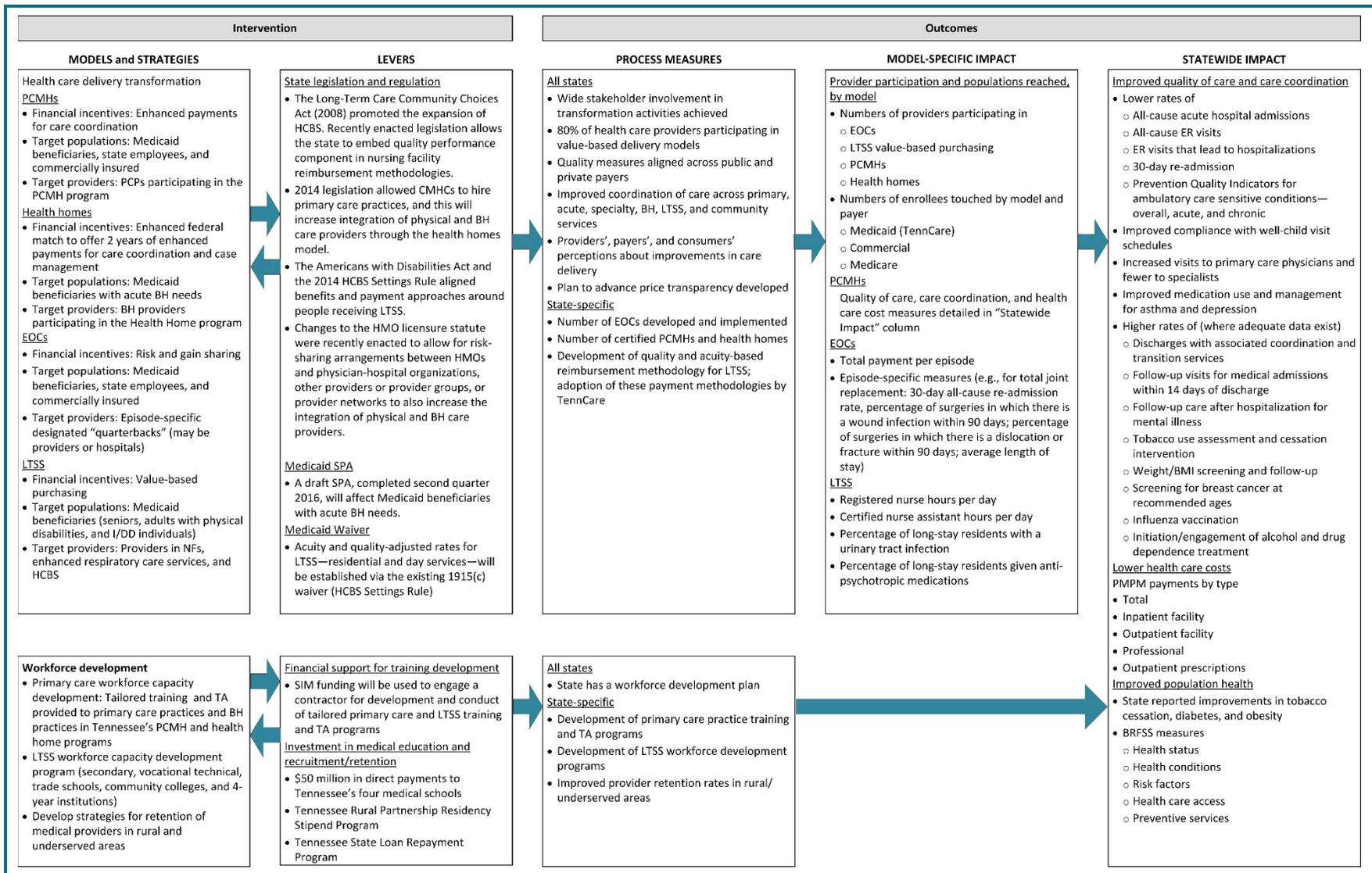
J.5 Overall Tennessee Summary

Tennessee is in the early stages of health care system transformation under the SIM Initiative. Nevertheless, based on information gathered from stakeholders during the 2016 site visit, the state is making progress in implementing EOCs, primary care transformation, and LTSS payment reform. EOCs have been implemented according to schedule, with all five waves

developed and the first two implemented. Health Link is on schedule to be implemented statewide in fourth quarter 2016, and PCMH implementation will begin January 2017. LTSS initiatives and development are also proceeding according to schedule. The statewide population health improvement plan is undergoing finalization.

Several aspects of implementation will require the state's attention over the coming year. Providers—particularly those in small, rural, and private practices—expressed the need for the tools, information, and support to make use of data reports and transform their practices. The utilization of EOC data reports will need to be monitored closely. It will also be important to monitor differences in SIM implementation in urban versus rural areas, since Tennessee is a geographically diverse state and barriers to implementation in rural areas will need to be considered in future roll-out efforts. Based on interviews with a variety of stakeholders, little is known about the population health components of the SIM Initiative; this plan needs to be finalized and widely disseminated to begin to make meaningful change on a population level. Gaining participation from payers other than TennCare and state employee plans will also be a significant but necessary step to ensure sustainability of the models and strategies implemented under the SIM Initiative. Nearly all stakeholders interviewed expressed support for health care system transformation in Tennessee, a state with significant health challenges, and are eager to see how the SIM Initiative will unfold across the state to affect quality, cost, and overall population health.

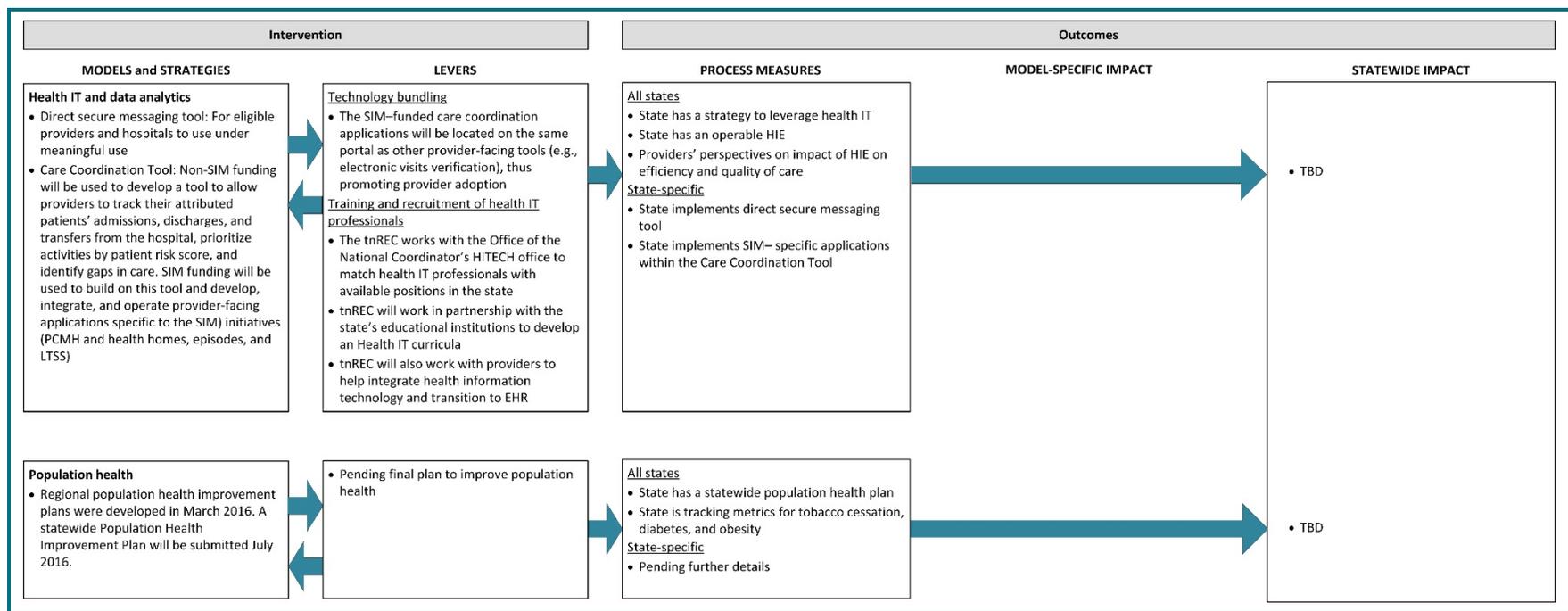
Figure J-1. Logic model for Tennessee’s State Innovation Model activities



J-25

(continued)

Figure J-1. Logic model for Tennessee’s State Innovation Model activities (continued)



J-26

BH = behavioral health; BMI = body mass index; BRFSS = Behavioral Risk Factor Surveillance System; CMHC = community mental health center; EHR = electronic health record; EOC = episode of care; ER = emergency room; HCBS = home- and community-based services; health IT = health information technology; HIE = health information exchange; HITECH = Health Information Technology for Economic and Clinical Health; HMO = health maintenance organization; I/DD = intellectual and developmental disabilities; LTSS = long-term services and supports; NF = nursing facility; PCMH = patient-centered medical home; PCP = primary care provider; SIM = State Innovation Model; SPA = state plan amendment; TA = technical assistance; TBD = to be determined; tnREC =Tennessee Regional Extension Center.

Appendix K: Washington Site Visit Report

The RTI team conducted the Washington site visit from May 4 through May 6, 2016. The team conducted 16 in-person interviews in Seattle and Olympia, and four telephone interviews after the visit. Interviewees included state officials, payers, providers, and consumer representatives. The team also conducted four focus groups in Seattle, two with Medicaid beneficiary consumers and two with clinicians whose patients included Medicaid beneficiaries. One consumer and one provider focus group were recruited to include individuals who received or provided care at Federally Qualified Health Centers (FQHCs).

This appendix provides an overview of the Washington State SIM Initiative; describes the current health care context in which the SIM Initiative is being implemented; summarizes early implementation successes, challenges, and lessons learned; and discusses key findings from the site visit interviews and focus groups organized by major topic area. This appendix includes findings based on qualitative data collected through June 30, 2016. Further details on the analytic approach are available in *Appendix L*. Information on the site visit interviewees for the state is in *Table L-1*, and information on the provider and consumer focus group participants for the state is in *Tables L-4* and *L-5*, respectively.

K.1 Overview of the Washington State Innovation Model

The Washington SIM Initiative is a component of the larger Healthier Washington project. The overall goals of Healthier Washington are to build the capacity to move health care purchasing from volume to value, improve the health of state residents, and deliver whole-person coordinated care. Washington state government sees itself as acting as a “first mover” in its implementation of the SIM Initiative, taking the lead by making changes in Apple Health (the state’s Medicaid program) and the state’s Public Employee Benefits Board (PEBB) program that provides health care coverage for state employees and their families. Through both programs, the state purchases health care for 2.2 million covered lives (of a state population of 7.06 million), spending \$10 billion per year.⁹³ A key contextual characteristic of SIM implementation is that many of the innovation transitions are being initiated gradually over time by region, building on pre-existing efforts, rather than statewide all at once. Through the SIM Initiative, Washington is making investments in five areas:

- ***Accountable Communities of Health.*** Washington has established nine regionally organized Accountable Communities of Health (ACHs) with the goal of bringing together local stakeholders from multiple sectors to act as “a lynchpin” in the SIM Initiative—to determine priorities for regional health improvement projects and implement these locally driven projects. Each ACH establishes its own governing

⁹³ Teeter, D. (2016, June 21). Increasing purchasing power in Washington State. Health Care Payment Learning & Action Network. Retrieved September 2, 2016 from <https://hcp-lan.org/2016/06/increasing-purchasing-power-in-wa-state/>.

structure and priorities and, as of July 2016, two of the nine regions had launched pilot projects.

- **Practice Transformation Support Hub.** The Hub is both a portal for resources for providers and an avenue for providing practice transformation assistance. To promote the proposed activities of the Hub, two requests for proposal (RFPs) have been released.
- **Payment redesign.** Washington has envisioned four models for payment redesign in various stages of implementation:
 - *Payment Model 1: Early Adopter of Medicaid Integration* is integrating Medicaid purchasing of physical health services with mental health and substance abuse services.
 - *Payment Model 2: Encounter-Based to Value-Based* is a value-based payment (VBP) methodology for Medicaid enrollees that individual FQHCs and Rural Health Centers can choose to adopt.
 - *Payment Model 3: Accountable Care Program and Multi-Purchaser* is an accountable care model for state employee PEBB enrollees. Two insurance plans (University of Washington Medicine Accountable Care Network [ACN] and Puget Sound High Value Network) became options for state employees in five counties in January 2016. Although state officials said they are pleased with an initial enrollment of 12,000 PEBB members, they said that total enrollment in both networks must rise over time for the plans to be sustainable.
- **Greater Washington Multi-Payer Data Aggregation Solution.** This is development of an integrated, multi-payer database strategy. State officials will contract with a lead organization to develop the database that will link information on Medicaid, public employees, and commercial marketplace enrollees—so providers can access consistent information on their patients. At the time of the May 2016 site visit, the contracting process was not yet completed.
- **Analytics, Interoperability, and Measurement.** Analytics, Interoperability, and Measurement (AIM) is bringing together ongoing health information technology (health IT) and data infrastructure efforts, connecting state data to clinical data systems to create a clinical data repository (CDR) and to assess population health. An AIM director was hired in April 2016 and has begun developing the analytic data infrastructure and AIM’s communication plan to promote work with stakeholders; the state is seen as a partner.

K.2 Logic Model

Figure K-1, located at the end of this appendix, is a logic model of Washington’s SIM Initiative, depicting the hypothesized relationships between specific elements of the SIM Initiative and changes in outcomes. Column 1 describes the scope of the payment models in terms of their financial operation, target populations, and target providers. It also presents highlights of other key strategies (across spheres of population health, consumer engagement, health IT, and workforce development). Column 2 describes the state and federal policy actions

that were part of the development of the SIM Initiative and/or will affect its implementation. These include regulations and legislation (expanded Medicaid enrollment, development of a state all-payer claim database, and pursuit of an 1115 Medicaid waiver), as well as changes in state statutory and budgetary authority.

Column 3 highlights process measures to capture implementation of the health care delivery models and other strategies. Column 4 links specific elements of the payment models to changes in outcomes. A primary goal of Payment Model 1 is to improve Medicaid beneficiary access and utilization of appropriate mental health services. Payment Model 3 aims to address quality of primary care through more consistent use of screenings and wellness assessments, participation in shared decision-making pilots, and improved coordination with specialty services. These changes in utilization patterns are expected to produce statewide changes, as shown in Column 5, encompassing improved quality of care and care coordination, lower health care costs, and improved population health.

K.3 Implementation Activities

K.3.1 Context of health care system

Washington has long been a leader in health care reform. One state official said, “Washington State is very optimistic and positive, and the state has a very collaborative culture in the health system space.” The Washington SIM Initiative—a component of the state’s more global health care reform effort, Healthier Washington—takes place within the context of pre-existing and concurrent initiatives. These include the Dr. Robert Bree Collaborative (Bree Collaborative), which develops evidence-based care recommendations; a common core set of health care measures used across payers; other CMMI awards; and a pending Section 1115a transformation waiver proposal. The Washington state legislature endorsed health care delivery system and payment reforms via several pieces of legislation passed in 2014 and 2015. SIM activities are designed to support and further these reforms. Additional detail on these efforts is discussed below.

The Bree Collaborative was established in 2011, through state legislation. Through the collaborative, stakeholder work groups comprising Governor-appointed public and private health care purchasers, health plans, health care providers, hospitals, and quality improvement organizations develop evidence-based recommendations to guide delivery of commonly used health care services. Health care services that are high cost, highly utilized, and have high variation in practice patterns and have been reviewed include low back pain, obstetric care, and addiction and dependence treatment. The state’s Health Care Authority (HCA) uses these recommendations as the basis for developing patient decision aids to guide the health care provided to Medicaid enrollees, state employees, and other groups. HCA plans to spread the use of the evidence-based guidelines through the Hub.

In support of SIM implementation, various key pieces of state legislation have been enacted. House Bill 2572, “Better Health Care Purchasing” (Chapter 223 of the laws of 2014), addresses the effectiveness of health care purchasing and the transformation of the health care delivery system through (1) establishing and funding the first two ACHs, (2) establishing a statewide performance measures committee, (3) creating the Hub, (4) establishing the all-payer claims database (APCD) and creating a safe harbor, and (5) directing the HCA to increase value-based contracting for Medicaid and public employees.

Section 6 of House Bill 2572 requires development of a statewide, core measures set to enable a common approach for tracking health and health care performance to measure health care quality and cost. Use of the measures is to start with the state government. As a purchaser and administrator of health care for Medicaid beneficiaries and public employees, Washington is intending to be a leader in the state in paying for value rather than volume. Washington’s SIM Initiative, the foundation for Healthier Washington, calls for eventual alignment of measurement across public and private payers, starting with the core measures set as the basic set of measures to which additional measures can be added. Fifty-two measures were agreed to by the Performance Measures Coordinating Committee in 2014 and reported on in 2015.

Senate Bill 6312, “Treating the Whole Person,” established steps for the phased approach to fully integrated Medicaid managed care by 2020. The legislation requires (1) behavioral health organizations to integrate chemical dependency and mental health services administration, (2) Medicaid purchasing to be aligned in regional service areas (RSAs), (3) incentives for early-adopters of full integration, (4) outcome-based performance, and (5) reciprocal contracting arrangements for co-located services. Other state legislation granted HCA’s chief medical officer the authority to certify patient decision aids, which (if signed by a patient) constitute informed consent; directed HCA to designate a private sector organization to lead implementation of the Washington State Health Information Exchange; directed the Office of Financial Management to establish the statewide APCD; and broadened the scope of telemedicine to enable its use in urban and underserved areas in addition to rural areas.

Washington is an active participant in other federally supported transformation activities in addition to the SIM Initiative. Stakeholders noted that these include five organizations with Transforming Clinical Practice Initiative awards, an Agency for Healthcare Research and Quality Health Hearts Northwest Evidence NOW grant (practice transformation), a CMS Partnership for Patients award with the Washington State Hospital Association, eight Health Care Innovation Awards from CMMI, and a very active Quality Innovation Network-Quality Improvement Organization. Stakeholders (including state officials, providers, payers, and consumer advocates) identified their involvement and opportunities for synergy across initiatives as a strength. However, some stakeholders also worried about the possibility of confusion or fatigue with transformation efforts, given their sheer number and magnitude.

On August 24, 2015, Washington submitted a Section 1115 Medicaid Transformation waiver request to CMS to support the goals of Healthier Washington. The waiver envisions ACHs as a backbone for regional transformation efforts, and as such, would provide ACHs with additional financial resources to improve health system performance for Medicaid beneficiaries at the local level. One payer expressed concern that parts of the waiver could, in fact, be at cross purposes with the ACH efforts now under way, due to lack of clarity regarding the specific roles of the ACHs.

Washington is organizing much of its SIM-supported health care transformation work regionally, building on pre-existing efforts. For example, mental health systems were regionalized in 1990, when they became regional support networks. The statute that promoted behavioral health organizational integration and early adopters of physical and behavioral health integration required creation of 10 RSAs. State officials from the HCA and the Department of Social and Health Services (DSHS) determined the map of the RSAs with input from the counties. The HCA is moving toward having Medicaid managed care organization (MCO) contracts overlap and align with the boundaries of the same regions. The state also is attempting to align ACH regions along the same map, although some variation remains. State officials indicated that this alignment of the ACH regions and the RSAs is a deliberate effort within the SIM Initiative to help create synergies across the set of SIM strategies.

According to many stakeholders, private sector initiatives also have helped pave the way for VBP reforms in the state, while others note that they tie into state-led efforts. Multiple stakeholders highlighted that the state has worked with Boeing, a large, local employer, and learned from its experience in developing its own accountable care model; Boeing has expressed interest in aligning the company's payment methodology with the broader Washington SIM Initiative. One provider stakeholder mentioned that Boeing began establishing ACNs several years ago. A state official highlighted Boeing's status locally, nationally, and internationally, and the organization's role as a spokesperson for transformation to value-based care. Also, health insurance carriers, such as Regence, are including value-based care in some of their products and are moving toward global costs of care.

K.3.2 Governance and program administration

The Governor's Office in Washington approved the policy direction for the state's SIM Initiative. An Executive Leadership team comprising the director of the HCA, the secretaries of DSHS and the state Department of Health (DOH), and two of the Governor's senior policy advisors provide strategic policy guidance.

With overall coordination provided by HCA, three state agencies share responsibilities for SIM implementation. HCA, as the administrator of Apple Health and PEBB, leads development of the various payment reform models. DOH leads development of the Hub and activities to improve population health. DSHS, which oversees provision of mental and

behavioral health services, provides expertise and data for development of Apple Health's integration of physical and behavioral health. Across the three agencies, a leadership team provides consultation and recommendations. Within each agency, frontline project managers work together as a team and meet regularly to carry out project work.

State agencies receive guidance and feedback on SIM activities through an advisory group of key stakeholders, known as the Health Innovation Leadership Network (HILN). With the goal of helping to accelerate the efforts of Healthier Washington, HILN consists of 55 members—including providers, businesses, health plans, unions, consumer and community representatives, local government entities, state government agencies, and tribal entities, among other key partners. HILN forms subcommittees as needed to provide guidance on specific strategies of health care transformation, focusing on such topics as communities and equity, clinical engagement, physical and behavioral health integration, and rural health integration. Stakeholders viewed HILN positively, describing it as a nonpartisan group that brings together private and public representatives who would not otherwise have the opportunity to exchange ideas and work together. Stakeholders suggested the state could do more to inform payers and consumer advocates about SIM implementation efforts between quarterly HILN meetings, and could better communicate how the different aspects of the SIM Initiative are anticipated to work together toward implementing VBP models statewide.

K.3.3 Stakeholder participation

For each SIM strategy, key stakeholders include consumers, providers, health plans, and purchasers (including employers). Within these categories, key stakeholders for the different SIM activities vary, depending on the population affected (e.g., Apple Health enrollees, state employees) and the health and social services sectors engaged in the activities under discussion. For example, each ACH includes a collaborative, decision-making body that engages a broad range of stakeholders—including local businesses, education, human services, and nonprofit organizations, in addition to health care service providers. State officials told the RTI team that the state historically has had good engagement from providers and consumers in the mental health community and is working on improving relations with the substance-use disorder community. The state has had less engagement with this community due to a lack of infrastructure to bring opinions forward but has added provider representatives from the substance-use disorder treatment community to HILN. Washington is working on improving its engagement with consumers through the Office of Consumer Partnerships.

The state has experienced challenges in working with tribal leaders on some elements of the SIM Initiative. A state official said the state recognizes the tribes' unique perspectives and needs and the unique relationship between tribes and the state, county, and federal government. In development of Payment Model #1 (see **Table K-1**), tribes contacted CMS directly and publicly to request that the state's waiver proposal be disapproved, because of concerns about delivery of substance-abuse treatment services. State and tribal officials reached a compromise,

Table K-1. Healthier Washington payment models

	Model 1	Model 2	Model 3	Model 4
Name	Early Adopter of Medicaid Integration (physical and behavioral health integration)	Encounter-based to Value-based (FFS to value-based) Purchasing	Accountable Care Program and Multi-purchaser (accountable care program)	Greater Washington Multi-Payer
Goal	Integrate Medicaid purchasing of physical health services with mental health and substance abuse services	Expand care delivery options for Medicaid beneficiaries in FQHCs and Rural Health Centers	Promote lower costs and higher quality experiences to public employees by executing risk-based contracts with provider networks	Test whether increasing providers' access to patient data across multiple payers increases their adoption of value-based reimbursement arrangements
Target population	Medicaid enrollees	Medicaid enrollees receiving services at FQHCs and Rural Health Centers	Public employees	Patients served by participating providers. (Providers are TBD)
Participating Payers	Medicaid via MCOs. In SW Washington: Community Health Plan of Washington and Molina Healthcare	Medicaid FFS and Medicaid MCOs	HCA via UW Medicine ACN and Puget Sound High Value Network	Medicaid, PEBB, Commercial payers (TBD)
Progress as of June 2016	Implemented in one region in SW Washington (Clark & Skamania Counties) as of 4/1/16	Negotiations between Medicaid and FQHCs	Implemented for five counties beginning January 1, 2016; ~12,000 enrollees	Implementation delayed

ACN = Accountable Care Network; FFS = fee-for-service; FQHC = Federally Qualified Health Centers; HCA = Health Care Authority; MCO = managed care organization; SW = Southwest; TBD = to be determined; UW = University of Washington

in which tribal members will be included in integrated mental health services but will continue to receive substance-use disorder services through a fee-for-service (FFS) model—to ensure tribal members can still receive culturally competent care in existing programs. In addition, one consumer advocate expressed concerns that tribal members were not adequately represented in planning for ACHs, that each tribe has its own voice (one tribe cannot speak for another tribe), and logistically, some tribal areas overlap with multiple ACH areas—with the implication that complete representation might require a tribe’s representative participating on multiple ACH boards.

Stakeholders expressed general agreement that the state has been open to and receptive of feedback provided about Healthier Washington and the implementation of individual SIM strategies. One provider commented that the state’s stakeholder engagement efforts included a

statewide “listening tour” to understand what providers need from the Hub. One payer commented, “We see great value in convening a broad range of individuals and organizations that otherwise would not come together to discuss what we believe are critically important changes that will really impact affordability, accessibility, and sustainability.”

However, consumer advocates expressed concern that consumers are not directly represented in stakeholder forums. These advocates felt that state officials are supportive of the concept of direct consumer engagement, but that logistical hurdles—such as child care, funds for consumer incentives to participate, identifying individual consumers who have the ability to express their beliefs among groups of professionals, and inclusion of multiple consumers—have stymied direct consumer engagement in SIM planning and implementation.

K.3.4 Delivery systems and payment reforms

Washington’s SIM Initiative focuses on changes in health care delivery and payment reform. The SIM Initiative also promotes the concept of whole person care through the integration of physical and behavioral health services.

Washington is testing four payment models, all of which are designed to move the state to paying for value rather than volume. The fourth payment model (Greater Washington Multi-Payer Data Aggregation Solution) is intended to enable providers to enter into value-based reimbursement arrangements with private payers, primarily by providing participating providers with access to a CDR. (Because the HCA’s role in Payment Model 4 is limited to providing the CDR, the model is detailed in section K.3.5, Health information technology and data infrastructure.) The payment models variously engage public (Medicaid, PEBB members) and private payers. As noted, state officials described the overall strategy as “state as first mover,” by leading with efforts that initially impact Medicaid and PEBB members.

Payment Model 1: Medicaid Physical and Behavioral Health Integration was developed in part as a response to state legislation requiring this service delivery integration for Medicaid enrollees across the state by 2020. HCA is implementing this integration via Medicaid MCOs. The integrated plan is rolling out in regions over the next 4 years. HCA is contracting with MCOs at financial risk for the full scope of Medicaid physical health, substance-use disorder, and mental health services, with the exception of crisis services. The model includes a 10 percent, shared-savings incentive resulting from the integration. Stakeholders engaged in designing Payment Model 1 included state agencies, regional service networks, community mental health centers, substance use disorder providers, and advocates.

In March 2015, HCA sent out a solicitation asking for communities to volunteer as early adopters of the integrated model, with an April 1, 2016, start date. Initially, state officials hoped for three early adopter areas, but only one area—Southwest Washington, one of the 10 RSAs—was prepared to take action quickly enough to meet the deadline. In this region, two health plans

contracted with Medicaid to offer integrated services: Community Health Plan of Washington and Molina Healthcare. The Medicaid managed care plans hold contracts with substance-use disorder and mental health providers, and authorize services as needed for enrollees. In the first year of implementing the integrated model, both the Community Health Plan of Washington and Molina Healthcare contracted with many of the same providers who had been providing mental health services in the FFS system. The MCOs may update their networks in the future, based on quality outcomes or ability to implement evidence-based practices. One payer mentioned that an ongoing challenge is integrating crisis services, which are provided by Beacon Health Options in Southwest Washington. Crisis services must be available to any individual, regardless of payer. To date, crisis services remain separate, or “carved out,” from the integration efforts.

Generally, key informants expressed positive opinions about the integration effort. Anecdotes about changes in individual Medicaid enrollee service use soon after Payment Model 1 implementation indicate that the integrated system has the potential to be successful. State officials told the RTI team that, since the Southwest region launched Payment Model 1 in April 2016, some high-risk, high-needs clients have already, in the first month, experienced a positive impact. Interviewed providers and payers viewed fully integrated purchasing for behavioral health services as a key opportunity for the state to improve payment and care delivery. However, both groups expressed some worries related to aspects of full implementation. One provider was concerned that the Model 1 payment methodology may be implemented before the delivery system is truly integrated, and that could create financial impediments in efforts to fully implement the model. Echoing this, payers emphasized that state support will continue to be critical, as integrated care models are rolled out in additional regions of the state.

Payment Model 2: Encounter-to-Value-Based Purchasing. Through Payment Model 2, HCA is leading the effort to design a VBP methodology for FQHCs and rural health clinics (RHCs) that provides more flexibility in their service delivery models than does the current, cost-based reimbursement encounter rate. SIM funds support development of the new methodology, including consultant and HCA agency staff activities. The state contracted with Health Management Associates to help design the VBP model. A state official explained that a key goal is to move away from encounter-based payments for FFS enrollees and allow Medicaid MCOs to design their own VBP arrangements with FQHCs and RHCs.

While many FQHCs in the state are already accredited patient-centered medical homes (PCMHs) and accustomed to some form of bundled payment, RHCs have less experience in this area. State officials and providers indicated that, because of this difference, finding a single, VBP model that can be applied to both FQHCs and RHCs has proven challenging. HCA regularly meets with representatives from the FQHCs, RHCs, and Medicaid MCOs, but Model 2 is not sufficiently developed to estimate a start date for its implementation. When the overall plan is in place, and individual FQHCs or RHCs are ready to do so, each will choose whether to switch to payments using the new, value-based model or continue under the current reimbursement

system. State officials, providers, and other stakeholders expressed frustration with the slow pace of developing the VBP model, as well as concerns that FQHCs and RHCs will have no opportunities to increase their reimbursement over current levels under a new payment system. One interviewee told us that the FQHCs need additional assurance they will receive service delivery transformation support, before they will be comfortable agreeing to change from a financially stable payment system.

Payment Model 3: Accountable Care Program. To develop Payment Model 3, HCA worked with PEBB to design an accountable care model for state employees. Known as ACNs, entities have agreed to risk-based contracts, assuming financial and clinical risk for PEBB members. In exchange, ACNs will be eligible for shared savings. Two insurance plans (University of Washington Medicine ACN and Puget Sound High Value Network) became options for state employees in five counties on January 1, 2016. In the first year, approximately 12,000 employees chose an ACN option, which state officials view as a successful start. SIM funds partially supported development of this model. State officials told us they consciously chose to focus on state employee benefits, because it allowed the state to use the policy lever of the state as a purchaser for initiating change toward efforts to pay for value rather than volume, which can then be replicated with private sector employers.

To promote buy-in, HCA included PEBB leadership in designing Payment Model 3. State officials indicated that the ACNs restrict the range of providers that enrollees can visit, which is a change some state employees may not like. On the other hand, an advantage of ACN enrollment is lower premiums and primary care visits without cost sharing, which is appealing to some state employees. HCA has worked to explain the new option to state employees, so they can make fully informed decisions. While state officials said they are pleased with the number of initial enrollees, they said total enrollment in both networks must rise over time for the plans to be sustainable. HCA officials continue to meet with clinical leadership at the two health plans, working collaboratively on quality improvement plans. These plans include steps to achieve National Committee for Quality Assurance (NCQA) or equivalent PCMH accreditation for primary care practices within the network, evidence-based protocols for complex care management for high-risk individuals, and implementation of Bree Collaborative recommendations.

To enhance delivery system coordination and integration with community-based social services, Healthier Washington has created ACHs, as noted. The state views the nine ACHs as key drivers of health system transformation. Each ACH brings together stakeholders from multiple sectors—health care providers, health plans, payers, human services, social services, and others—to determine priorities for regional health improvement projects. One state official described the ACH as “a lynchpin in the SIM [Initiative],” designed to connect many of the state’s investments and promote community involvement in the move toward VBP. Healthier Washington uses SIM funds to support the infrastructure and staffing of the ACHs. Each ACH

names a “backbone organization,” as described above, and establishes its own governance structure. Limited project funding is available through the SIM Initiative, for which ACHs must apply. While most ACHs are still in the planning stages, in two of the regions’ pilot communities already have been launched: the Cascade Pacific Action Alliance ACH and the North Sound ACH. At the time of the 2016 site visit, other pilots were planned to be launched throughout 2016 and 2017.

Stakeholders interviewees expressed a variety of opinions about ACH implementation. They told of confusion about the legal structure of the ACHs and their role in receiving and disbursing funds from SIM-related grants or other sources. A state official concurred that ACHs are the component of the SIM Initiative that stakeholders have the most questions about. One provider expressed concern that ACH activities may compete with existing community service organizations, and that existing entities, such as public health agencies and community health centers, were not adequately included in ACHs. Another provider said that providers generally are skeptical of the sustainability of ACHs, because they rely on a largely volunteer effort to convene multiple stakeholders. A consumer advocate expressed concern that ACHs are insufficiently funded. Several interviewees expressed their hope that the Medicaid transformation waiver, currently under consideration by CMS, would be approved, because it would funnel a larger amount of new funds to ACHs to support their continued efforts. However, state officials reiterated that ACHs are not limited to Medicaid populations and thus are broader than efforts to be undertaken through the Section 1115 waiver. Other stakeholders noted that, while the ACHs’ regionally based structure is useful for addressing local health needs, the differing initiatives of the individual ACHs could lead to a less cohesive, statewide impact.

K.3.5 Health information technology and data infrastructure

Washington is using its SIM Initiative to bring together some of its ongoing health IT and data infrastructure efforts in a more systematic way, connecting state data systems to clinical data systems to assess population health. To this end, Washington created the AIM strategy, under Healthier Washington, as part of its SIM award. AIM is staffed by HCA, DSHS, and DOH, with input from Healthier Washington stakeholders (including state agencies and health care organizations). One stakeholder said, “The analytics and measurement parts of the AIM initiative are absolutely key to understanding whether we are making headway on improving quality and lowering price, therefore getting better value.” However, this component of the Washington SIM Initiative has been slow to begin. A director for the AIM strategy was hired in spring 2016; at the time of the 2016 site visit, stakeholders anticipated further AIM-related activity in the following months.

AIM draws on existing and ongoing state efforts, including the APCD, a statewide common measures set, and a CDR now being established. Currently, 20 data suppliers contribute claims and quality data to a voluntary APCD, managed by the Washington Health Alliance. On May 14, 2015, the state enacted legislation to create a mandatory APCD, which will also require

the reporting of cost data. The state's Office of Financial Management released an RFP soliciting a vendor to build the APCD on April 15, 2016. The Supreme Court's March 1, 2016, decision in *Gobeille v. Liberty Mutual*⁹⁴ exempts self-funded employee health plans from mandatory participation in an APCD, but a payer that was interviewed said its organization plans to continue contributing voluntarily and anticipates others also will choose to participate.

In June 2014, the Governor of Washington appointed five stakeholders to oversee selection of a statewide, common measurement set—including individuals from academia, provider organizations, health plans, purchasers, and tribal health and state agencies. The Performance Measures Coordinating Committee is co-chaired by HCA and the Washington Health Alliance. Three work groups—focused on prevention, chronic illness, and acute care, respectively—each recommended metrics that could be used to measure quality of care. After public comment, 55 measures were finalized in December 2014. An additional work group focusing on behavioral health measures revised the measurement set to include behavioral health measures in 2016.

HCA contracts with the Washington Health Alliance under the SIM Initiative to publicly report annually on the common measures. The state is using the metrics in the common measures set to evaluate the quality of care delivered through Payment Model 3. Discussions are also under way about how to apply the common measures set to ACH performance. State officials were generally very satisfied with these measures. However, one state official criticized the common measures set as neglecting to capture measures that could be used to evaluate outcomes for individuals with the most complex needs.

Washington also is establishing a CDR to implement the Greater Washington Multi-Payer Data Aggregations Solution (i.e., Payment Model 4). The CDR will make clinical data, including physical and mental health information, available to providers to improve care delivery and to state officials for performance measurement. Through the CDR, the state will test whether increasing providers' access to patient data across multiple payers increases their adoption of value-based reimbursement arrangements. State officials plan to contract with a lead organization to help determine how to create data linkages among Medicaid, public employees, and the commercial insurance market enrollees, so providers can access consistent information about their patients, regardless of payer source. State officials reported challenges in establishing the CDR. The vendor initially contracted to build the CDR filed for bankruptcy, delaying much of the work until a new vendor was hired. Technical issues, as well as data security and data sharing regulations, have added to the complexity of building the CDR. Still, state officials expressed optimism that providing clinical data, including behavioral health data, to providers will bring positive results in the end. Stakeholders interviewed in spring 2016 described implementation of these efforts as just beginning.

⁹⁴ *Gobeille v. Liberty Mutual Insurance Company*, 136 S. Ct. 936 (2016)

K.3.6 Workforce development

Washington's primary mechanism for workforce development under the SIM Initiative is the Hub, which will connect providers to community resources and tools promoting more effective and efficient practice. DOH has primary responsibility for the Hub, which will be supported by funding from the SIM Initiative as well as other sources. State officials started the process of designing the Hub by conducting a series of provider listening sessions across the state, to learn about ongoing practice transformation activities and ways the Hub could most help providers. The listening sessions identified three priority areas: (1) integration of behavioral health and primary care, (2) clinical-community linkages, and (3) helping providers move to value-based purchasing. As a result, DOH has released two RFPs for Hub-related activities, as noted. The first solicits a regional health connector to coordinate clinical-community linkages. One of the provider interviewees viewed the regional health connector concept as a very promising way to provide regionally targeted assistance to practices in their efforts to transform to value-based care. The second RFP seeks a practice coaching vendor. State officials said the Hub will continue to collect tools and resources over time to help providers with practice transformation. These may include developing learning collaboratives and disseminating shared decision-making tools.

One payer identified the challenge of aligning the work of the Hub, administered by DOH, with the HCA-led payment reform but praised the coordination between the two agencies. State officials and providers said they are analyzing the intersection between the various practice transformation efforts under way in Washington, several of which are funded by CMMI, so the Hub can offer tools to help multiple, ongoing projects and minimize duplication.

K.3.7 Population health

In 2013, prior to the SIM Initiative, DOH and HCA developed a population health improvement blueprint, the Prevention Framework. The parameters of this framework were informed by state health data on disease rates and causes, as well as information from public health departments and community health needs assessments. The Prevention Framework enhanced connections between public health initiatives and the health care delivery system, and is the precursor to development of SIM's Plan for Improving Population Health (P4IPH). The P4IPH will align the state's existing population health efforts and serve as the state's strategic plan for population health priorities. The multisector-focused P4IPH will provide public and private partners with guidance on implementing population health improvement strategies across systems and agencies. At the end of 2015, the P4IPH team was fully staffed and preparing to work with an intra-agency council and an external advisory board to develop the P4IPH, which state officials indicated would be completed in fall 2016.

Additionally, with their focus on integrating medical and community-based services and implementing regional health improvement projects, the ACHs serve a key role in the SIM Initiative's population health efforts. Stakeholders described the ACHs' multisector approach to

prioritizing and investing in population health activities at the local level as holding promise for improving health and health equity. One state official described the ACHs as a key, system-level investment in addressing the social determinants of health and identifying existing policy levers to improve population health. Another commented that the SIM Initiative has helped to better integrate public health into health care delivery and create community and clinical linkages, because of DOH's engagement in the ACH work and the overall SIM Initiative.

K.3.8 Technical assistance and other support resources

State officials said they had limited experience with receiving technical assistance from the SIM program team beyond the weekly calls with CMMI. One state official described a positive experience, in which CMMI connected Washington with another SIM2 awardee state for advice on designing practice transformation support. Several state officials noted that the CMMI site visit was helpful and that they gained a greater understanding of what CMMI has observed in the state's SIM implementation.

K.3.9 Progress, challenges, and lessons

Washington has begun implementing several of the SIM Initiative's key strategies. Although progress has been uneven, areas of early implementation success are beginning to appear. One notable success has been Washington's explicit "state as first mover" strategy. This strategy is apparent in the early emphasis on Payment Models 1 and 3—where Medicaid and PEBB, respectively, provide policy levers for change. Strategies that require engagement from other stakeholders are moving more slowly, as the SIM leadership builds necessary relationships to support those changes. As one state official explained, "As first mover, the state can move a lot. But from a provider perspective, you need to get everyone going with you."

Stakeholders identified a range of challenges in implementing the various components of Healthier Washington generally, and the SIM Initiative specifically. Provider organizations, in particular, noted challenges faced by practices and their primary care providers (PCPs) in their capacity to move to a VBP approach, given existing limitations in staffing levels and other resource constraints—because the transition may require resource investments that can only be recouped later. Other stakeholders noted that six payers have most of the commercial market share in the state, and because it is a competitive market, these payers have sought to differentiate themselves. This could pose a challenge in implementing value-based purchasing statewide in a standardized way. Some interviewees were uncertain whether ACHs are sustainable, given the voluntary nature of these organizations. State officials noted that one big challenge is to "knit it all together," and expressed hope that the Hub can help play that role. If and when the Section 1115a waiver is approved, state officials noted that the SIM Initiative will need to further coordinate with activities under the waiver.

State officials identified a few early lessons learned. One is to be cognizant of provider and initiative fatigue, among stakeholders and state employees implementing Healthier

Washington and related transformations. A second lesson is the importance of communication across different types of stakeholders, who may not use similar terminology to refer to the same concept. Finally, a state official commented that it has been helpful to be selective in choosing individual vendors for specific aspects of Healthier Washington, rather than using one large contractor for multiple tasks.

Stakeholders the RTI team spoke with had mixed views about whether funding and other resources are sufficient to implement Healthier Washington as envisioned. Some state officials pointed out that Washington received only about two-thirds of the funds the state requested under its SIM award, which necessarily constrains what the state can accomplish. Nevertheless, stakeholders expressed an overwhelmingly positive outlook on the multisector stakeholder engagement process, and the payment and delivery system reform opportunities provided by the Washington SIM Initiative. Said one interviewee, “When you bring \$65 million to a state to set audacious goals and say do interesting, innovative things, it motivates collaboration and provides resources to jumpstart activities you may not otherwise be able to jumpstart.”

K.4 Statewide Changes

This section discusses statewide changes related to the SIM Initiative. The RTI team presents activities and progress in each area, organized according to each of the SIM Initiative’s major goals, as well as stakeholders’ perspectives.

K.4.1 Health care expenditures

A key goal of Washington’s SIM Initiative is lowering expenditures. At the baseline 2016 site visit, stakeholders discussed the state’s overall approach and considerations related to its potential success in this area.

One provider described the FFS system as inflationary, motivating the incentive to implement a system that rewards value. In response, the state legislature mandated identification of areas of high-cost medical care and development of evidence-based clinical approaches and practices. Stakeholders described Healthier Washington as working toward lowering costs through reducing service variability and improving price transparency among purchasers, payers, and employers.

Several state officials expressed the view that Washington state government, as a large purchaser of health care, is key to exerting leverage for changing the overall payment approach in the state. While the number of public employees who enrolled in the first two ACNs in the first year (2016) was smaller than state officials had hoped, they anticipate the uptake will expand as the relative cost of care increasingly favors the ACNs.

However, some stakeholders were skeptical about the ability of these changes to meaningfully reduce total health care expenditures. A consumer advocate expressed concern that

the change to VBP may not produce the promised financial benefit impact. He cited the Massachusetts experience, where expectations were high but, in the end, benefits were modest. He further expressed the concern that success required a large percentage of commercial plans to change their contracts. Payers could end up making more modest changes, such as five percent withholds with bonuses for meeting performance goals. If the risk is not as large as it might be, the financial result could be much smaller. Lastly, providers expressed the concern that resources are already stretched and that these new changes will require that they do more with less.

K.4.2 Health care utilization

Health care utilization includes access to care, as well as the level and type of services obtained. Challenges in Washington include ensuring appropriate utilization of primary care services and adequate access to specialty care, when needed.

Both interviewees and focus group participants noted access to care concerns in the state at the time of the May 2016 site visit, particularly related to specialty care. Multiple stakeholders recognized that large, newly insured, and poor minority populations are generally not healthy; rather than using primary care services for prevention purposes, they come to clinics needing specialty services to manage existing health conditions. Medicaid beneficiaries voiced access to specialty and dental care as challenges, citing the limited number of providers that accept Apple Health. PCPs participating in focus groups echoed the difficulty of scheduling appointments with specialists for Medicaid enrollees. One of those providers and a consumer advocate separately noted an increase in the number of specialists requesting that referrals for Apple Health enrollees be scheduled through Project Access Northwest Specialty Care Coordination, which these interviewees believed makes it more difficult to access those services in a timely manner.

Some Medicaid beneficiary focus group participants reported being able to obtain an appointment with their PCP within a week when they are sick, but others indicated that they need to go to urgent care facilities or emergency rooms (ERs) to receive care. Over half of Medicaid beneficiary focus group participants reported having visited an ER in the last year, and some said they had gone multiple times. Some beneficiaries noted an unhelpful change—from waiting a long time in waiting rooms to see their PCP to being brought to an exam room quickly and then having to wait there for 20 to 30 minutes. Medicaid beneficiaries were generally aware of the availability of patient portals as an alternative means to communicate with their providers, but few said they use them, and those who do, only minimally.

The state will evaluate progress related to appropriate service utilization using the state's core set of performance measures, which include measures related to access to primary care and prevention services (e.g., access to PCPs, weight assessment, medical assistance with tobacco cessation, cancer screenings) and avoiding overuse (e.g., avoidance of imaging for lower back pain, potentially avoidable ER use).

The new payment models being implemented through the Washington SIM Initiative are intended to address access and utilization of appropriate services. For example, Payment Model 2 will enable the state to test whether greater financial flexibility for FQHCs and RHCs can support expanded and innovative delivery care models (e.g., email, telemedicine, group visits) and improve access to services.

Washington's other three payment models are intended to reduce inappropriate utilization of services. For example, the main goal of integrating physical and behavioral health care financing in Payment Model 1 is to deliver more continuous, whole-person care, which should reduce avoidable ER visits and hospital stays among Medicaid beneficiaries receiving behavioral health services in the participating regions. Furthermore, a goal of Payment Model 3's ACN initiative is to decrease inappropriate utilization. Participating networks are required to document implementation of Bree Collaborative, evidence-based recommendations for high cost, high utilization, and high variation in service delivery (e.g., potentially avoidable hospital readmissions) across network providers.

However, with HCA's emphasis on "paying for value" and not volume, some stakeholders expressed that, although they are in agreement that the approach is positive conceptually, they worried they do not yet fully understand "what it actually mean[s] to be responsible for value" and the new problems that could result in its implementation. Stakeholders were concerned that consumers might not get the services they need, and providers could be incentivized to avoid high-cost patients in worse health. For example, one stakeholder expressed concern that the state is not ready to implement the new approach among the vulnerable portion of the patient population, who have chronic conditions and do not sufficiently understand the health care system. These patients do not necessarily use primary care appropriately. A provider was concerned that certain staff may provide clinical value but not be financially viable in a VBP approach. Multiple consumer advocates said that, even if paying for value is the right anchor strategy, local resources are currently limited, and community infrastructure linkages are weak. According to these advocates, to meaningfully link clinical and community services during the SIM Initiative implementation period will be a challenge.

K.4.3 Care coordination

Care coordination is a key SIM component. Stakeholders discussed activities the state is undertaking, a variety of challenges to successful care coordination, and their positive expectations and reservations concerning the SIM Initiative's ability to improve the state's health care delivery system (through new payment models, workforce development, provider education, local initiatives, and data enhancements).

Most stakeholders were aware of ongoing care coordination activities in the state. Consumer advocates noted "pockets of amazing work happening," but that the work is not universal across the state. One state official also hinted at this, noting that "behavioral health and

physical health do not exist in a vacuum outside of a community,” and that “different counties have different connectivity.” Another state official highlighted the need for increased incentives toward integration in rural counties as compared to larger, urban counties, due to the latter’s greater, county-based infrastructure and resources.

Among providers, care coordination was considered very important, and one provider noted that they are “learning how to do it,” especially in challenging situations (e.g., for complex patients). Medicaid beneficiary focus group participants felt that providers should make more referrals, especially to specialty providers, and these beneficiaries voiced appreciation for nontraditional health care providers that made referrals to specialists in traditional medicine. In juxtaposition, one payer mentioned looking at different avenues to achieving better care coordination, most notably in primary care, by getting people the right care without referral to specialists, and by using technology. Few Medicaid beneficiaries said they have care managers and generally find them helpful in managing care. A consumer advocate noted that challenges to care coordination included needing staff who can assist patients whose first language is not English (e.g., Tribal and Asian populations), but highlighted appreciation for progress to date in efforts that have been made toward culturally competent community health workers and care coordinators. Stakeholders rarely noted alternative methods of care coordination, such as telehealth. One payer noted progress toward robust care networks, and to developing models, like the mental health integration program, that focus on building capacity in primary care clinics to serve individuals with depression, anxiety, and more complex mental health conditions (e.g., bipolar disorder, posttraumatic stress disorder).

Stakeholders expressed an appreciation for various approaches to care coordination as a component within the SIM Initiative. A state official noted that care coordination is an explicit expectation within Payment Model 1 (integration of behavioral and physical health services into a seamless delivery and payment system). State officials described the Hub as another valuable care coordination strategy, especially in connecting providers to community resources. One state official believed that Payment Model 1 and the Hub will have the greatest impact on care coordination, both by putting care coordination into contracts and by providing transformation support to practices.

One payer noted, however, that the care coordination focus and goal may not be realistic for various reasons, including complexity due to provider systems, plans, and each ACN doing care coordination its own way; and the need for “coordination of the coordinators.” This payer noted that discussions about this have revealed a healthy degree of cynicism. Similarly, providers expressed the need for restraint in expectations concerning the speed of implementation—with one provider reflecting that it will be a multiyear journey, and not something that can be achieved in 6 months.

State officials also noted external barriers—workforce issues regarding training, differences in behavioral health practice and clinical coordination, and the impact of the Health

Insurance Portability and Accountability (HIPAA) on data sharing. One state official noted the limitations of the SIM Initiative, particularly within the context of HIPAA requirements—specifying the need for clarification concerning care coordination policy issues, and that people will be less likely to try changes unless there is policy change or direction from the federal government. HIPAA most clearly affects the APCD, a platform that integrates data across multiple payers and delivery systems, with the aim of facilitating provider-led improvement in care coordination and population health management.

Stakeholders expressed concern about the interaction between payers and providers. One payer noted that many large payers view health care as part of their supply chain, and expect a good product. The onus for provision of the health care “product,” in their view, falls on the provider. In this respect, payers do not see their role as teaching providers how to produce better health care. A state official expressed the view that payers, in holding the delivery systems accountable for cost and quality in pursuit of the Triple Aim⁹⁵ (the normal work for the delivery system), will hold providers contractually accountable to work with partners to make sure they can coordinate care. However, another state official highlighted that, if providers are held accountable for coordinating care for certain hard-to-serve populations, such as the severely mentally ill in jails and ERs, they will need help from community resources and coordination with housing providers and other groups.

In this context, multiple stakeholders discussed the role of ACHs in care coordination. State officials said the ACH role was to help providers understand what community resources were available and what these resources have to offer to support clinical care. Stakeholders noted that within an ACH, success could be summed up as “partnership”—specifically, getting partners to talk in detail about how care coordination is being funded, and to think in the context of the community with an eye toward “whole-person care.” Importantly, one payer expressed the concern that providers do not believe the ACH effort is sustainable, given that it relies on volunteers, as noted, and that the ongoing, necessary convening of the various constituent parties can be difficult to maintain.

Care coordination measures are included in Washington’s core set of SIM quality measures. One state official said that such measures inform “everything we do,” and that the state wants to provide support to providers in understanding the purpose of the measures set. One provider highlighted that greater emphasis on measures and performance targets driven by HCA and the SIM Initiative will require all providers to develop a plan for how they are going to achieve their care coordination targets (including high-risk care management targets). The state is presently working with Payment Model 2 providers to help them select measures that will inform their decisions. They will identify three to five core measures for payment from among six common measures. Payment Model 1 has 10 measures, and Payment Model 3 has 19. For

⁹⁵ Berwick, D. M., Nolan, T. W., & Whittington, J. (2008). The triple aim: Care, health, and cost. *Health Affairs*, 27(3), 759–769. doi: 10.1377/hlthaff.27.3.759

providers, outcomes include better quality of life, reducing preventable ER use and hospital readmissions, and addressing mental health issues. One state official noted that it is unclear whether ACHs will be given a common set of measures, or if each ACH will continue to focus on the set of community measures it works on already.

K.4.4 Quality of care

Improving quality of care is a theme across a number of Washington's SIM components. To support physician practice transformation, the Hub is being established by region. Payment models are being designed to reward quality improvement. Quality of care performance measures are being developed to ensure expectations are transparent and shared across stakeholders.

One payer reported that consumer experience, an important indicator of care quality, has improved notably. All Medicaid beneficiary focus group participants rated the health care they receive as eight or higher on a scale of 10. A majority said they feel their PCPs listen to what they have to say and are accommodating, although the PCPs do not always explain things in language that is easy to understand. Over half felt like they are part of a team with their PCP, but most said 15-minute appointments are not long enough to address all the concerns they want to discuss. Medicaid provider focus group participants reported being progressively asked to do more for their patients, but without the flexibility to spend a significant amount of additional time with them.

The state's Hub efforts are intended to create a culture of quality improvement and shared learning among providers. One state official said the Hub was specifically designed in response to listening sessions with providers. The Web portal will include a range of tools and resources, sorted by RSA, that are evidence based and tied to best practices, to support the aims of practice transformation. The Hub's regional health connectors are seen by state officials as a much-needed opportunity to coordinate quality improvement between clinical providers and the ACHs, which may target quality of care improvements themselves through locally driven projects. These connectors will guide providers through practice coaching, referral to technical assistance, and training. One key element of this SIM activity is to develop shared, decision-making aids to engage consumers in their own health care decisions.

Washington's payment models share the goal of improving quality of care. For example, Payment Model 1 should provide more comprehensive and earlier screening, and greater continuity of care for consumers with behavioral health needs. Payment Model 2 links gain-sharing and risk to quality improvement under a population-based, pay-for-performance system for FQHCs and RHCs. Payment Model 3 requires networks participating in an ACN to participate in the state's shared, decision-making pilots for maternity care, total joint replacement, and end-of-life care; participate in existing community, quality improvement

programs related to obstetrics, cardiology, and spine care; and invest in infrastructure to promote PCMH standards (NCQA PCMH Level III standards or equivalent) across network providers.

One provider expressed the belief that transparency in how quality of care and consumer experience with care are measured and presenting the information in an understandable manner for consumers, may be the most impactful strategy of the Washington SIM Initiative. The focus of the state’s core set of performances measures is to evaluate progress on improving health care quality among multiple stakeholders. This goal includes measuring management of behavioral health conditions (e.g., follow-up after hospitalization for mental illness or discharge from the ER for mental health or alcohol or other drug dependence, psychiatric inpatient readmissions) and chronic conditions (e.g., medication management for people with asthma, blood sugar testing and control for people with diabetes, blood pressure control for people with cardiovascular disease), and effective hospital-based care (e.g., all-cause hospital readmissions, caesarean deliveries, catheter-associated urinary tract infections).

K.4.5 Population health

The concept of population health is held in high esteem in Washington, but it is not a concept with one meaning that is uniformly shared among stakeholders. State officials said they realize population health can have different meanings to different stakeholders. For example, the concept may spur providers to think of their patient panel, while ACHs may conceptualize population health in terms of the larger regional geography. One payer noted that population health focuses on the individual, and by doing so, population health is positively affected in the aggregate.

One state official took a higher-level perspective and put population health in the context of clinical populations, with health improvement in each clinical population acting to improve aggregate population health. Multiple state officials and payers took a still more macro approach—believing it is important to consider the broader social determinants of health to have a greater positive impact. State officials emphasized social determinant factors, community linkages, and bridging the roles of the community and the clinic—with, as encapsulated by one official, “the clinical system [being] only part of it.” One state official referred to developing “language that works” as an issue of national policy; another noted a distinction between population health (e.g., understanding the leading causes of mortality, Quality Adjusted Life Year) and health of populations (considered as a health improvement model), and the importance of moving from one to the other.

Throughout the site visit interviews, despite the definitional differences, state officials highlighted population health efforts to date. One pointed out the work of Healthier Washington in relation to community health assessments. Another noted that a long-standing priority of HCA is to promote connections between public health, providers, and payers, leading to development of the state’s Prevention Framework as a blueprint for pre-SIM population health improvement

(which the same official felt can and will be built on as a tool to improve population health). State officials, as well as consumer advocates, explicitly saw a key role for ACHs in improving whole population health (a role not exclusively focused on state purchased programs).

Across stakeholder types, interviewees emphasized how population health is a fundamental SIM component, as reflected in its focus for both an internal and an external work group under the SIM Initiative. In terms of specific SIM strategies, stakeholders did not associate the Hub with population health—even though its goals include strengthening clinical practice alignment with community-based services for whole-person care, and establishing robust and effective linkages between providers and community resources.

The Washington SIM Initiative common measure set does include population health measures. A state official noted that under the SIM Initiative, measurement of progress in population health will be based on making positive progress on such measures as improving the immunization rate and reducing the number of people with prediabetes. One payer referenced screening and prevention goals as items in the common measure set they monitor; that payer also said that, by focusing on the same measures, they can see how their enrollees align with population goals. Another payer noted that provider feedback on the common measure set was initially disagreement with the indicators and other results, although stakeholders recognizing that the responsibility for improving population health does not lie with the provider alone has helped. Yet another payer noted that there has been a lot of discussion about population health, and about having standard, consistent measures, not only within Washington but from one state to another—and that this conversation has included appropriate infrastructure and alignment of the financing model.

Washington's P4IPH, the focal point for population health under the SIM Initiative, is intended to guide how the state and local communities can best implement population health improvement strategies. State officials noted that, led by DOH, the development and completion of the P4IPH is an avenue for ensuring that the Healthier Washington initiative addresses prevention, health equity, and social determinants of health. Hinting at a perceived lack of fluidity among SIM components, a state official described integrating the P4IPH into other SIM activities as difficult, with the perception of population health as a disparate area that the SIM Initiative brings together with other disparate areas (e.g., payment models). Given the role of ACHs in population health in Washington, however, one state official noted that the P4IPH will be a relevant tool and resource for these entities. The state plans to house P4IPH resources on the Hub in 2017.

In terms of leadership of the population health component under the SIM Initiative, one payer noted that who is in charge and who is going to be in charge is amorphous. Lack of clarity or consensus regarding appropriate SIM activities related to population health limits expectations of impact. The success of the SIM Initiative will depend on overcoming challenges; and stakeholders consistently mentioned the need for additional data as a challenge. A state official

noted that health IT enhancements are needed for state data systems to be connected to clinical data to assess population health. A consumer advocate noted that the challenge and opportunity lies in creating new, informative data systems. A payer noted, “It’s building a communication infrastructure, a shared data utility ... that is going to be critical for population health management.”

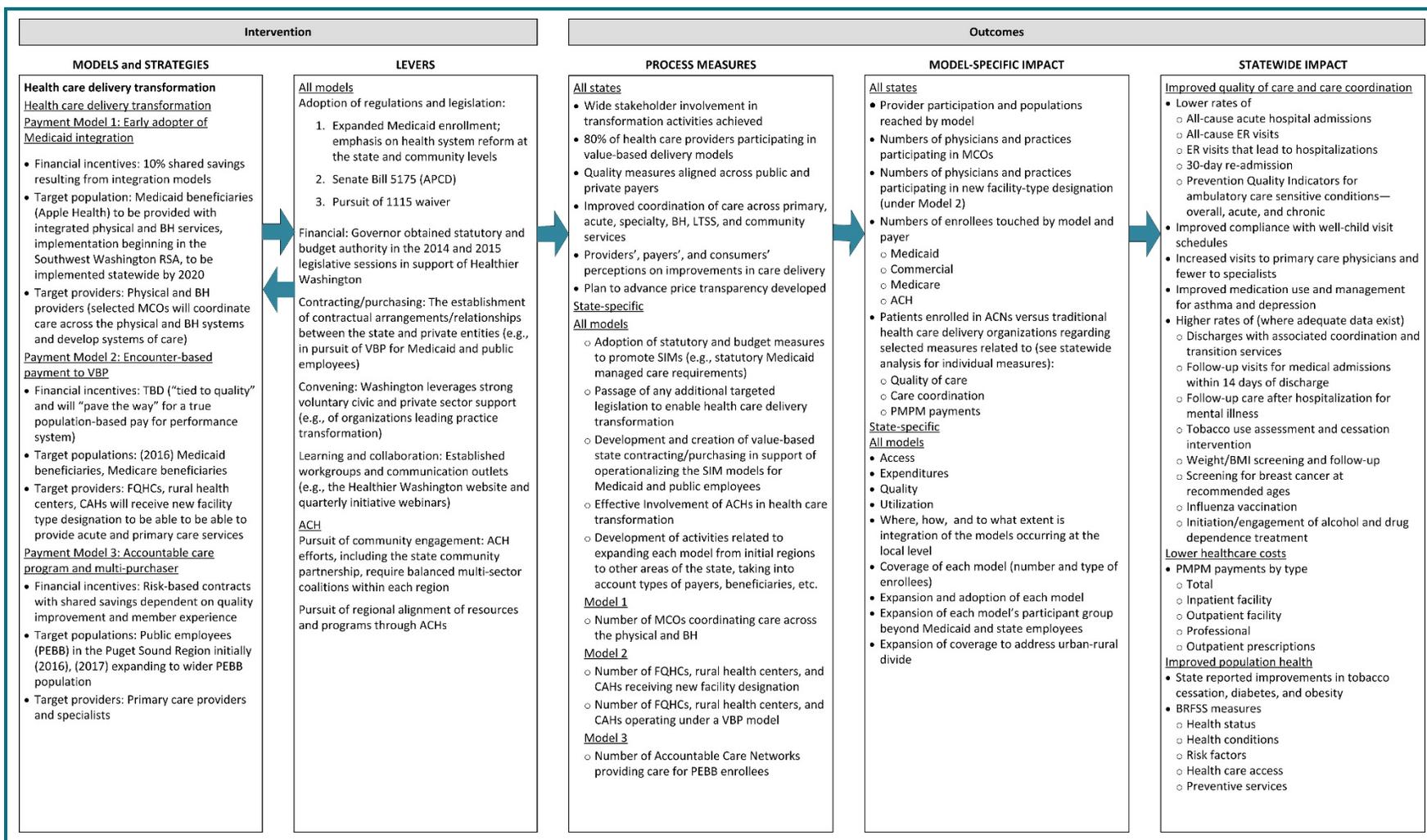
Regarding social determinants of health, a consumer advocate noted that the state’s “single best accomplishment is the community linkage of our health care delivery system to our social determinant of health organizations,” which (1) has “been successful in both the urban areas of Spokane and the rural areas, linking the social and delivery system”; and (2) ensures that housing organizations, school districts, and so on, are “at the table.” The same consumer advocate also noted that the SIM Initiative has helped to strengthen the community-based efforts of the managed care plans, which “have deepened the relationships with the social determinant of health organizations.” Another state official noted that health systems are being asked to be accountable for preventable ER visits and jail admissions. Health care systems and providers cannot do this on their own; they need to be connected to housing providers and different groups providing psychosocial services locally—this is where the ACHs come into the population health picture.

K.5 Overall Washington Summary

The Washington SIM Initiative is a component of the state’s larger Healthier Washington initiative. Of the four payment models the state has proposed, two have been implemented by the state government as a first mover—taking the lead by making changes in the programs for which the state is a payer and administrator. Model 1 changes health care delivery to Medicaid beneficiaries (Apple Health) and includes a focus on integrating physical and behavior health. Model 3 implements an Accountable Care Program option for state government employees. Model 2, which is being finalized more slowly, promotes greater financial flexibility for FQHCs and RHCs to implement VBP methodologies; an expanded APCD includes cost as well as quality measures. Other key SIM activities under development include the practice transformation support Hub to provide resources and coaching to providers, and improvements in health IT and the state’s data infrastructure.

Regional implementation is a key strategy. ACHs have been established in each of the regions to create a structure for local input and to lead unique community initiatives, but many stakeholders remain unsure about their structure, funding, and role, particularly in relation to other SIM activities. Overall, stakeholders said that they were provided with an opportunity to participate in the health care transformation decision-making process.

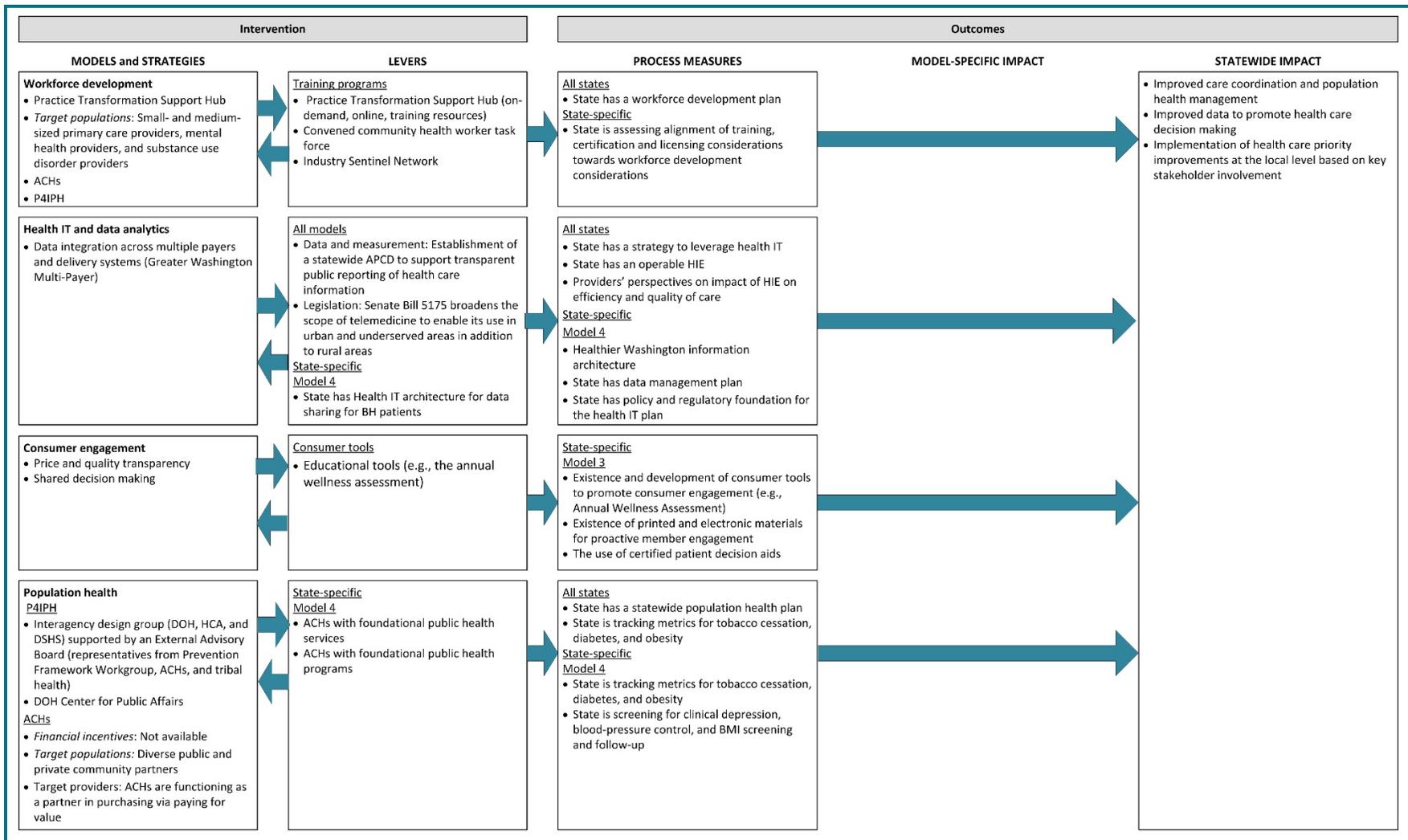
Figure K-1. Logic model for Washington’s State Innovation Model activities



K-24

(continued)

Figure K-1. Logic model for Washington’s State Innovation Model activities (continued)



K-25

ACH = Accountable Community of Health; APCD = all-payer claims database; BH = behavioral health; BMI = body mass index; BRFS = Behavioral Risk Factor Surveillance System; CAH = critical access hospital; DOH = Department of Health (Washington); DSHS = Department of Social and Health Services (Washington); ER = emergency room; FQHC = Federally Qualified Health Center; HCA = Health Care Authority (Washington); health IT = health information technology; HIE = health information exchange; LTSS = long-term services and supports; MCO = managed care organization; P4IPH = Plan for Improving Population Health (Washington); PEBB = Public Employee Benefits Board; PMPM = per member per month; RSA = regional service area; SIM = State Innovation Model; TBD = to be determined; VBP = value-based payment.

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Appendix L: Site Visit Qualitative Data Collection

The RTI team collected and analyzed various sources of qualitative data for evaluation of the SIM Initiative. The collection process included regularly participating in state check-in calls for the Round 2 Model Test states, reviewing state documents, collecting relevant news articles, holding monthly evaluation calls with most Round 2 Model Test states, and conducting stakeholder interviews and provider and consumer focus groups during 3-day site visits. This appendix provides a description of the methods used for the data collection efforts during the Year 1 (2016) site visits.

L.1 Stakeholder Interviews

From April to June 2016, we conducted our first of three rounds of site visits to Round 2 Model Test states. The site visits consisted of both key informant individual interviews and focus groups with providers and consumers. Overall, the 11 state evaluation teams conducted 201 interviews—ranging from 16 to 20 interviews per state. The key informants included the states' SIM teams, state officials, commercial payers, providers, consumer representatives, and health infrastructure personnel.

We began selection of key informants by soliciting suggestions from the state SIM teams for interview candidates, and identified additional interview candidates from review of relevant documents. We made the final selection of key informants based on state-specific SIM model considerations. Final lists of site visit interviewees were not shared with state SIM teams or CMMI. The lists remained confidential and were only shared within the relevant state evaluation team. **Table L-1** provides a distribution of the completed interviews by state and interviewee type. Consistent with our focus on implementation issues for the site visits, the majority of interviews were with state officials.

The interviews during the first site visit will serve as a baseline assessment and continue as a critical reference point to assess change and impact in future years. Discussion topics included:

- Understanding the context and setting in which Round 2 of the SIM Initiative is being implemented
- Outlining details of the models and enabling strategies implemented by the Model Test states under the SIM Initiative Round 2
- Understanding the anticipated outcomes/impacts and indicator of success
- Specifying relevant state initiatives that pre-existed SIM
- Assessing stakeholder engagement in the design and implementation of the Round 2 Model Test state models and strategies
- Describing the governance and administration of the SIM award.

Table L-1. Interviews conducted in Round 2 Model Test states by state and stakeholder type, as of June 30, 2016

State	State officials	Payers	Providers & medical associations	Consumer/patient advocates	Other	Total
Colorado	7	2	4	2	3	18
Connecticut	8	3	3	2	0	16
Delaware	8	2	4	1	1	16
Idaho	9	3	3	3	0	18
Iowa	3	3	3	2	6	17
Michigan	5	2	9	1	0	17
New York	12	3	3	1	2	21
Ohio	7	6	3	2	0	18
Rhode Island	9	2	7	4	0	22
Tennessee	9	3	4	2	0	18
Washington	9	2	5	3	1	20
Total	86	31	48	23	13	201

Table L-2 describes the specific topic areas the interview protocols covered, by type of interviewee.

We also modified the interview protocols to include an additional series of questions for “other” key stakeholders, as necessary. These questions may have been related, for example, to health information technology or health information exchange, or directed to particular populations (e.g., the Native American population).

Prior to the interviews in each state, we provided state officials with information outlining our understanding of that state’s SIM Initiative, which was based on our document review and prior communications with the state. We then requested these officials to confirm the accuracy of our information.

Between one and three stakeholders participated in each interview. We held the interviews in the offices or locations of the interview participants. In particular instances where key informants were unavailable to interview in person and/or at the time of the site visit, we conducted the interview via telephone either prior to or following the site visit. The interview lead used discussion guides to structure each interview session, and a designated note taker recorded the feedback from each session, which typically lasted no more than 1 hour.

Table L-2. Site visit interview topic areas by key informant type

Topic areas	State officials	Payers	Providers & medical associations	Consumer/patient advocates
About the respondent	X	X	X	X
Overall progress on SIM Initiative operational model activities	X	—	—	—
Governance and policy levers	X	—	—	—
Stakeholder participation	X	X	X	X
Health care delivery transformation	X	X	X	X
Payment system reform	X	X	X	—
Population health	X	X	X	X
Health IT and other investments	X	X	X	X
Workforce	X	X	X	—
Outcomes and impacts	X	X	X	X
TA and other support resources	X	—	—	—

health IT = health information technology; SIM = State Innovation Model; TA = technical assistance.

Note: X = Yes; — = No

State evaluation team members conducted each interview in pairs; however, in rare instances when availability allowed, more than two conducted an interview. One team member led the interview, while a second interviewer was a designated note taker and took written notes of the information from each session. To ensure consistency across state teams, we trained the interviewers and note takers before the interviews. These trainings clarified the role of each individual, provided interviewing guidelines, and reviewed note-taking conventions specific to both focus groups and individual interviews.

We encouraged participants to share the feedback most relevant to their particular roles in the SIM Initiative. To encourage candid discussion, we informed participants that we would not identify them individually or attribute specific comments to individuals in subsequent reporting. We ensured participants that we would only use anonymous quoted words and phrases from the interview notes to convey perspectives of particular interest.

We used a digital recorder to create an audio recording of the interviews. Prior to using the equipment, we obtained permission from all interviewees and instructed them that recording could be stopped at any time. We then used the recordings to confirm the notes' accuracy and to gain clarification as needed. All audio recordings and interview notes were securely stored. The evaluation team members stored both recordings and notes on a secure storage system, and encrypted files prior to any necessary transfers.

L.2 Focus Groups

To conduct baseline data on the perspectives and experience with care coordination and care management, we also conducted focus groups during the 2016 site visit to each Round 2 Model Test state—two groups with consumers and two groups with providers. *Table L-3* presents the topic areas for both provider and consumer focus groups.

Table L-3. State Innovation Model Round 2 evaluation site visit focus group topic areas

Topic areas	Providers	Consumers
About the respondent	X*	X**
Healthcare access	X	X
Provider knowledge	—	X
Patient health behavior	—	X
Patient engagement	X	—
Electronic health/health IT	X	X
Healthcare practice	X	—
Care coordination	X	X
SIM Initiative	X	—

* For example, type, focus, patient population.

** For example, likes/dislikes of their health care.

health IT = health information technology; SIM = State Innovation Model.

Note: X = Yes; — = No

We recruited focus group participants from the provider and consumer populations in each state that were most likely to be impacted by each state’s delivery system models being tested under the SIM Initiative Round 2. We held these focus groups in one or two locations in each state, selecting locations with a sufficient concentration of the targeted populations from which to recruit participants. Once we determined the types of focus group participants and locations, the state evaluation teams worked with the Model Test states to acquire lists of names and contact information for individuals within the target population groups. To ensure focus groups of sufficient size, we requested lists with a much larger number of individuals than we intended to have as participants, to ensure participation goals would be met. For every 12 desired focus group participants, we typically requested a recruitment list of at least 100 individuals.

The evaluation team recruited consumer and provider focus group participants through telephone calls. Prior to those calls, we sent potential participants advance letters that informed them about the data collection, introduced them to CMS and the RTI team, and invited them to volunteer to participate. When there was incomplete contact information for potential consumer participants, we performed telematch and other methods to identify or confirm contact information. With the use of state-specific screening scripts, we screened potential participants

by phone to determine their eligibility for the groups. In general, consumer participants had to be over 18 years of age and have had at least one visit to a health care provider in the prior 6 months; provider participants had to have been practicing at least 2 years and have a current caseload of more than 50 patients. During the telephone recruitment process, the recruiters gave participants information regarding compensation for travel and time spent. We compensated each consumer \$75 and each provider \$300. The recruiters contacted participants a few days prior to, as well as the evening before, the focus group session, to confirm participation and provide additional details regarding logistics.

Tables L-4 and L-5 show the focus group sites and the number and population type recruited for each state, for the provider and the consumer focus groups, respectively. Across the 11 Round 2 Model Test states, the state evaluation teams conducted 22 provider focus groups and 22 consumer focus groups in all—two per state of each focus group type. Four to 10 providers participated in each provider focus group (172 total, or ~8 per group), and 4 to 10 consumers participated in each consumer focus group (173 total, or ~8 per group).

Table L-4. Participation in provider focus groups

Model test state	Focus group type	Provider type	Location	Number of participants
Colorado	Provider group 1	Behavioral health	Denver	10
	Provider group 2	Primary care	Denver	9
Connecticut	Provider group 1	FQHCs	Hartford	10
	Provider group 2	AMHs	New Haven	8
Delaware	Provider group 1	Primary care	Wilmington	6
	Provider group 2	Primary care	Wilmington	8
Idaho	Provider group 1	Primary care-PCMH	Boise	8
	Provider group 2	Primary care-PCMH	Boise	9
Iowa	Provider group 1	Primary care	Fort Dodge	5
	Provider group 2	Primary care	Des Moines	8
Michigan	Provider group 1	Primary care-PCMH	Flint	7
	Provider group 2	Primary care-PCMH	Jackson	8
New York	Provider group 1	Primary care-PCMH	Albany	5
	Provider group 2	Primary care-PCMH	Albany	8
Ohio	Provider group 1	Primary care	Cleveland	5
	Provider group 2	PAPs	Cleveland	4
Rhode Island	Provider group 1	Primary care	Providence	9
	Provider group 2	Behavioral health	Providence	9
Tennessee	Provider group 1	Primary care	Nashville	8
	Provider group 2	Primary care	Memphis	10
Washington	Provider group 1	FQHCs	Seattle	10
	Provider group 2	non-FQHCs	Seattle	8

AMH = Advanced Medical Home; FQHC = Federally Qualified Health Center; PAP = principal accountable provider; PCMH = patient-centered medical home

Table L-5. Participation in consumer focus groups

Model test state	Focus group type	Population	Location	Number of participants
Colorado	Consumer group 1	Medicaid beneficiaries	Denver	9
	Consumer group 2	Medicaid beneficiaries	Denver	6
Connecticut	Consumer group 1	Medicaid beneficiaries	Hartford	7
	Consumer group 2	Medicaid beneficiaries	Hartford	10
Delaware	Consumer group 1	State employees	Dover	9
	Consumer group 2	Medicaid beneficiaries	Wilmington	9
Iowa	Consumer group 1	Medicaid beneficiaries	Fort Dodge	8
	Consumer group 2	Medicaid beneficiaries	Des Moines	5
Idaho	Consumer group 1	Medicaid beneficiaries	Boise	6
	Consumer group 2	Medicaid beneficiaries	Boise	8
Michigan	Consumer group 1	Medicaid beneficiaries	Flint	9
	Consumer group 2	Medicaid beneficiaries	Jackson	10
New York	Consumer group 1	State employees	Albany	10
	Consumer group 2	State employees	Albany	8
Ohio	Consumer group 1	Medicaid-Chronic Conditions	Cleveland	8
	Consumer group 2	Medicaid-Episodes	Cleveland	9
Rhode Island	Consumer group 1	Behavioral health Medicaid beneficiaries	Providence	9
	Consumer group 2	Behavioral health Medicaid beneficiaries	Providence	7
Tennessee	Consumer group 1	Medicaid beneficiaries	Memphis	5
	Consumer group 2	Medicaid beneficiaries	Memphis	9
Washington	Consumer group 1	Medicaid beneficiaries at FQHCs	Seattle	4
	Consumer group 2	Medicaid beneficiaries at non-FQHCs	Seattle	8

FQHC = Federally Qualified Health Center.

Focus group composition varied by state, based on specific care models and target populations. **Table L-6** provides information on the provider focus group types represented in each state, with medical doctors (MDs)/Doctors of Osteopathic (DOs)/primary care providers (PCPs) being the most common provider category (about 45%), followed by registered nurses/nurse practitioners/physician’s assistants (about 35%). Social workers, counselors, and psychologists also participated, as did therapists, which were the least represented category. Colorado’s provider focus group represented all category types; in contrast, Delaware’s and Ohio’s provider focus groups represented only the MD/DO/PCP category.

Table L-6. Provider type across provider focus group

State	MD/DO/ PCP*	Nurse**	Physician assistant (PA)	Psychiatrist/ psychologist	Social worker/ counselor***	Therapist
Colorado	X	X	X	X	X	X
Connecticut	X	X	X	—	—	—
Delaware	X	—	—	—	—	—
Iowa	X	X	X	—	—	—
Idaho	X	X	X	—	X	—
Michigan	X	X	X	—	X	—
New York	X	X	—	—	—	—
Ohio	X	—	—	—	—	—
Rhode Island	—	X	—	X	X	—
Tennessee	X	X	—	—	X	—
Washington	X	X	—	—	—	—

* Includes prenatal, pediatric, and emergency medicine specialists.

** Includes registered nurse and nurse practitioner.

*** Includes mental health and addiction.

DO = Doctor of Osteopathic; MD = medical doctor; PA = physician’s assistant; PCP = primary care provider.

Note: X = Yes; — = No

A single evaluation team member moderated the focus groups across all 11 Round 2 Model Test states, with occasional comoderation by a state evaluation team member. Each focus group lasted under 2 hours, including time to review the focus group processes and obtain informed consent. The focus group moderators used discussion guides customized for each state’s SIM Initiative, and the evaluation teams audio-recorded the discussions (ensuring participant confidentiality, as with the interviews, and saying the recording could be stopped at any point). We recorded the focus group discussions to ensure accuracy of the statements and to facilitate note taking. Following the groups, state teams prepared summary notes and findings.

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**Appendix M: State Innovation Model Initiative Round 2 Model Test
States' Involvement in Other State, Private, and Federal Delivery
System and Payment Transformation Initiatives**

Table M-1. State Innovation Model Initiative Round 2 Model Test states' involvement in other state, private, and federal delivery system and payment transformation initiatives

Initiatives	CO	CT	DE	ID	IA	MI	NY	OH	RI	TN	WA
State initiatives											
Community Care Team Pilot					Yes						
Intensive Care Management		Yes									
Medicaid/CHIP ACOs	ACC				Yes (c)		Yes		Yes		(d)
Medicaid/CHIP medical homes		Yes		Yes	Yes	MIChAP	Yes	Yes	Yes		
Other medical homes				Yes			Yes		Multi-payer		
Episode-based payment							Yes		(e)		
Private initiatives in state											
ACOs	Yes	Yes			Yes (Wellmark)		Yes				
Medical home/care coordination initiatives				Yes		PGIP	Yes	Yes			
Episode-based payment							Unknown				
Primary care transformation initiatives											
Multi-Payer Advanced Primary Care Practice Demonstration ^a						Yes	Yes		Yes		
Comprehensive Primary Care Initiative ^a	Yes						Yes	Yes			
Comprehensive Primary Care Plus	Yes					Yes	Substate	Yes	Yes	Yes	
FQHC Advanced Primary Care Practice Demonstration ^a	Yes	Yes		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Innovation Accelerator Program				Yes				Yes			Yes
Medicaid Delivery System Reform Incentive Payment Program							Yes				
Transforming Clinical Practice Initiative	Yes	Yes	Yes	(f)	Yes	(f)	Yes	(f)	Yes	Yes	Yes
ACO initiatives											
Medicare Shared Savings Program ^a	Yes	Yes	Yes		Yes		Yes	Yes	Yes		
Pioneer ACOs ^a					Yes	Yes	Yes				
Investment ACOs ^a	Yes				Yes					Yes	

(continued)

M-2

Table M-1. State Innovation Model Initiative Round 2 Model Test states' involvement in other state, private, and federal delivery system and payment transformation initiatives (continued)

Initiatives	CO	CT	DE	ID	IA	MI	NY	OH	RI	TN	WA
ACO initiatives (continued)											
Advance Payment ACOs ^a		Yes						Yes	Yes	Yes	
Next Generation ACOs ^a					Yes	Yes					
Nursing Home Value-Based Purchasing Demonstration ^a							Yes				
Other federal initiatives											
AHRQ Evidence Now Southwest	Yes						Yes				
Financial Alignment Initiative: State Demonstration Grants to Integrate Care for Dual Eligible Individuals ^b	Yes					Yes	Yes	Yes	Yes		Yes
Health Care Innovation Awards ^a	Yes	Yes	Yes	(e)	Yes						
Community-Based Care Transitions Program ^a					Yes	Yes	Yes	Yes			
Independence at Home Demonstration ^a			Yes			Yes	Yes	Yes			
Bundled Payments for Care Improvement Initiative ^a	Yes										

Data sources: ^a CMS Innovation Center (2016). ⁹⁶ ^b Centers for Medicare & Medicaid Services. (2016, September 12). ⁹⁷

^c Iowa's Wellness Plan is no longer operational.

^d Washington is pursuing Medicaid ACOs (effective March 2016).

^e Rhode Island is establishing bundled Medicaid rates for persons with severe and persistent mental illness/severe mental illness. Also, three hospitals and some home health agencies are operating with bundled payment models.

^f Only out-of-state model/demonstration/initiatives are operating in the state (i.e., the primary awardee's location is not in the state).

ACC = Accountable Care Collaborative is Colorado's Medicaid primary care case management program launched in 2011; ACO = accountable care organization; AHRQ = Agency for Healthcare Research and Quality; CHIP = Children's Health Insurance Program; CMMI = Center for Medicare and Medicaid Innovation; FQHC = Federally Qualified Health Center; MiCHAP = Michigan Children's Health Access Program in nine counties in northwest Michigan; PGIP = Physician Group Incentive Program of Blue Cross/Blue Shield of Michigan.

⁹⁶ CMS Innovation Center. (2016). *Innovation models*. Retrieved October 4, 2016, from <http://innovation.cms.gov/initiatives>.

⁹⁷ Centers for Medicare & Medicaid Services. (2016, September 12). *Financial alignment initiative*. Retrieved October 4, 2016, from <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsInCareCoordination.html>.

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