

State Innovation Models (SIM) Round 2

Model Test Annual Report Three

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RTI International

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Acronym List

ACC	Accountable Care Collaborative	CCM	chronic care management
ACH	Accountable Community of Health	CCT	care coordination tool
ACN	Accountable Care Network	CDC	Centers for Disease Control and Prevention
ACO	accountable care organization	CDPHE	Colorado Department of Public Health and Environment
ACP	Accountable Care Program	CEO	chief executive officer
ADT	admission, discharge, and transfer	CHEMS	community health emergency medical services
AE	Accountable Entity	CHIP	Children’s Health Insurance Program
AIM	Analytics, Interoperability, and Measurement	CHIR	Community Health Innovation Region
AMH	Advanced Medical Home	CHITA	clinical health IT advisor
AN	Advanced Network	CHOICe	Community Health Outcome Improvement Coalition
APC	Advanced Primary Care	CHT	community health team
APCD	all-payer claims database	CHW	community health worker
APM	alternative payment model	CMHC	community mental health center
APN	advanced practice nurse	CMMI	Center for Medicare and Medicaid Innovation
AR	Annual Report	CMS	Centers for Medicare & Medicaid Services
ASC	Accountable System of Care	COPD	chronic obstructive pulmonary disease
ASO	Administrative Services Organization	CPC+	Comprehensive Primary Care Plus
AY	Award Year	CQM	clinical quality measure
BCBS	Blue Cross Blue Shield	CTC	Care Transformation Collaborative
BH	behavioral health	CY	Calendar Year
BHI	behavioral health integration	DCHI	Delaware Center for Health Innovation
BHO	behavioral health organization	DE	Delaware
BHTC	behavioral health transformation collaborative	DFS	Department of Financial Services
BMI	body mass index	DHIN	Delaware Health Information Network
BRFSS	Behavioral Risk Factor Surveillance System	DHS	Department of Human Services
C3	Community and Clinical Care initiative (formerly Community Care Coalition)	DHSS	Delaware Health and Social Services
CAH	critical access hospital		
CAHPS	Consumer Assessment of Healthcare Providers and Systems		
CBO	community-based organization		
CCIP	Community and Clinical Integration Program		

DO	Doctor of Osteopathic Medicine	HITECH	Health Information Technology for Economic and Clinical Health
DOH	Department of Health		
DPH	Department of Public Health	HITO	health information technology officer
DSP	direct service provider	HJR	House Joint Resolution
DSRIP	Delivery System Reform Incentive Payment	HMA	Health Management Associates
DSS	Department of Social Services	HN	Healthy Neighborhood
ECF	Employment and Community First	HRA	Health Risk Assessment
ECHO	Extension for Community Healthcare Outcomes	Hub	Practice Transformation Support Hub
eCQM	electronic clinical quality measure	I/DD	intellectual and developmental disabilities
ED	emergency department	IAPD	implementation advanced planning document
EGD	esophagogastroduodenoscopy	IBH	integrated behavioral health
EHR	electronic health record	IDHW	Idaho Department of Health and Welfare
EOC	episode of care	IDPH	Iowa Department of Public Health
EOHHS	Executive Office of Health and Human Services	IEP	Individualized Education Plan
ER	emergency room	IHC	Idaho Healthcare Coalition
ERC	Enhanced Respiratory Care	IHDE	Idaho Health Data Exchange
FFS	fee for service	IHIN	Iowa Health Information Network
FQHC	Federally Qualified Health Center	IT	information technology
GI	gastrointestinal	LAN	Learning and Action Network
GME	graduate medical education	LPHA	local public health agency
HCA	Health Care Authority	LTSS	long-term services and supports
HCBS	home- and community-based services	MACRA	Medicare Access and CHIP Reauthorization Act of 2015
HCCD	Health Care Claims Database	MCO	managed care organization
HCP	Health Care Payment	MCP	managed care plan
health IT	health information technology	MD	medical doctor
HEC	Health Enhancement Community	MDHHS	Michigan Department of Health and Human Services
HEDIS	Healthcare Effectiveness Data and Information Set	MI	Michigan
HEZ	Health Equity Zones	MiHIN	Michigan Health Information Network
HIE	health information exchange	MiPCT	Michigan Primary Care Transformation
HILN	Health Innovation Leadership Network	MLR	Medical Loss Ratio
HIPAA	Health Insurance Portability and Accountability Act		

MLTSS	managed long-term services and supports	PediPRN	Pediatric Psychiatry Resource Network
MSSP	Medicare Shared Savings Program	PF	practice facilitator
NCQA	National Committee for Quality Assurance	PM	Payment Model
NF	nursing facility	PMO	Project Management Office
NP	nurse practitioner	PMPM	per member per month
NQF	National Quality Forum	PSI	Prevention Service Initiative
NY	New York	PT	practice transformation
NYC	New York City	PTA	practice transformation agent
NYS PCMH	New York State Patient-Centered Medical Home	PTO	practice transformation organization
NYS	New York State	Q	quarter
NYSDOH	New York State Department of Health	QA	quality application
OBH	Office of Behavioral Health	QHP	qualified health plan
OFM	Office of Financial Management	QI	quality improvement
OH CPC	Ohio Comprehensive Primary Care	QMRT	Quality Measure Reporting Template
OHIC	Office of the Health Insurance Commissioner	QPP	Quality Payment Program
OHS	Office of Health Strategy	QuILTSS	Quality Improvement in Long-Term Services and Supports
OHT	Office of Health Transformation	RC	Regional Health Collaborative
ORC	Ohio Revised Code	RCO	Regional Care Organization
P4IPH	Plan for Improving Population Health	RFA	request for authorization
P4V	pay for value	RFP	request for proposals
PA	physician's assistant	RHC	rural health clinic
PC	primary care	RI	Rhode Island
PCI-A	Percutaneous Coronary Intervention–Acute	RIDOH	Rhode Island Department of Health
PCI-N	Percutaneous Coronary Intervention–Non-acute	RN	registered nurse
PCMH	patient-centered medical home	ROI	return on investment
PCMH+	Person Centered Medical Home Plus	ROMC	Regional Oversight and Management Committee
PCP	primary care provider	SAMHSA	Substance Abuse and Mental Health Services Administration
PDF	Portable Document Format	SB	Senate Bill
PE	participating entity	SBIRT	Screening, Brief Intervention, and Referral to Treatment
PEBB	Public Employee Benefits Board	SDoH	social determinants of health
		SEHP	state employee health plan

SHIN-NY	Statewide Health Information Network for New York	TCPI	Transforming Clinical Practice Initiative
SHIP	State Health Care Innovation Plan	THA	Tennessee Hospital Association
SIM	State Innovation Model	TN	Tennessee
SOS	System of Support	UConn	University of Connecticut
SPLIT	Shared Practice Learning and Improvement Tool	UW	University of Washington
SSD	Social Services Directory	VBID	value-based insurance design
SSP	shared savings program	VBP	value-based payment
SWAN	Statewide Alert Notification	VIS	Value Index Score
T&TA	Training and Technical Assistance	WA	Washington
TA	technical assistance	WA-APCD	Washington All-Payer Claims Database
TAG	Technical Advisory Group	Y	year
TCC	total cost of care		

Executive Summary

State governments have the potential to accelerate statewide health care system transformation through the many roles they play—as legislators, regulators, conveners, and both suppliers and purchasers of health care services. To that end, the Center for Medicare and Medicaid Innovation’s (CMMI’s) State Innovation Model (SIM) Initiative awarded more than \$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**. The SIM Initiative’s primary objective is to assist states in meeting a “preponderance of care,” the CMMI goal¹ of having at least 80 percent of care in a state—defined on the basis of population, expenditures, or practices—in delivery arrangements that use value-based payment (VBP) or alternative payment models (APMs) to incentivize better care and lower costs.² To achieve this goal and foster health care system transformation, state SIM Initiatives are using policy and regulatory levers to enable or facilitate the spread of innovative health care models, integrating behavioral health and population health into transformation efforts, engaging a broad range of stakeholders, and leveraging existing efforts to further improve health care delivery outcomes. All states commonly provided infrastructure, such as health information technology (health IT) and learning opportunities, to enable providers to transform care delivery.

The Year 3 Annual Report (AR3) of the SIM Round 2 evaluation contract analyzes data collected between May 1, 2017, and March 30, 2018, the AR3 analysis period. The report (1) describes findings on the adoption of delivery models and payment reforms related to VBP and APMs, including progress toward achieving a preponderance of care; (2) provides an update and lessons learned on the main enabling strategies to support health care delivery transformation in quality measure alignment, health IT and data infrastructure, and practice transformation and workforce development; and (3) describes states’ efforts and challenges in improving population health. Brief overviews of the findings in these three key areas follow.

¹ Rajkumar, R., Conway, P. H., & Tavenner, M. (2014). CMS—engaging multiple payers in payment reform. *JAMA*, 311(19), 1967–1968. doi: 10.1001/jama.2014.3703

² VBP is a strategy used by purchasers to promote the quality and value of health care services. The goal of VBP programs is to shift from pure volume-based payment, as exemplified by fee-for-service payments, to payments more closely related to health outcomes. An APM is any approach meeting the criteria established by the Centers for Medicare & Medicaid Services (CMS) that gives added incentive payments to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population. Advanced APMs are a subset of APMs that let practices earn more rewards in exchange for taking on risk related to patient outcomes. Source: CMS. (2017). APMs overview. *Quality Payment Program*. Retrieved from <https://qpp.cms.gov/apms/overview>.

ES.1 Status of Payment Reform under Round 2 of the State Innovation Model Initiative

Alignment among payers in VBP strategies has been a central tenet of SIM-supported payment reform strategies. Prior to May 2017, states focused primarily on the implementation of payment reforms in Medicaid, where state purchasing levers are strongest. States had early expectations that success of SIM-supported initiatives in Medicaid would serve as the value case for private payers, but broader participation had yet to materialize. By the outset of the AR3 analysis period, stakeholders recognized that certain conditions arising in health insurance and provider markets resulted in low provider participation in VBP, low payer participation, or both. While states have been aware of these challenges, understanding their implications for reform initiatives and identifying a path forward has taken time.

States adjusted payment reform strategies in response to providers' and payers' constraints. States used three major approaches to achieve the degree of alignment they believed was needed to expand VBP adoption: (1) adapting SIM-supported models, (2) facilitating multi-payer coordinated action, and (3) adding VBP targets or requirements through procurement or other mechanisms. In states that added new strategies for alignment during the AR3 analysis period (Delaware, Michigan, New York, Rhode Island, Tennessee, and Washington), many health plans signaled that this shift would result in broader adoption of VBP in their state. In all states, payers broadly acknowledged that progress to date on VBP adoption would not have been possible without the SIM Initiative.

States explored several additional strategies in response to constraints. The most significant change to a SIM-supported model during the AR3 analysis period occurred in New York, where the state established a new unified patient-centered medical home (PCMH) model to meet the standards required of both Medicaid and private payers. An example of a new procurement lever is Washington's new requirement for the third-party administrator for the public employees' Uniform Medical Plan to contract with ACNs in its commercial product. The most novel process for alignment or "coordinated action" was planned for two New York regions, where SIM-supported regional collaboratives facilitated a cooperative decision among commercial plans to jointly encourage many small practices toward PCMH recognition.

From the outset of the SIM Initiative, states have experienced three hurdles to statewide VBP adoption and will continue to contend with them. The first hurdle is the challenge of recruiting small, independent practices to participate in VBP contracting. Small practices experience more difficulties in meeting requirements for participation in PCMH models, submitting required quality measures, and meeting the minimum patient numbers to support reliable measurement. The same challenges that inhibit small, independent practices from participating in VBP contracts also limit practice capacity to assume risk. The second hurdle involves statewide shortages of health care workers essential for delivery transformation

and the task of creating sustainable payment streams to ensure the engagement of health care providers in APMs. The third hurdle is lack of federally facilitated models to transform delivery and payment in rural markets, where Medicare is a dominant payer. Although currently only in the design stage, Washington's multi-payer rural reform initiative is the first and only proposed state model under SIM to engage *all* rural payers, including Medicare, to identify solutions.

States continue to collect data from payers and submitted measures to CMS on progress toward reaching 80 percent preponderance of care. At the end of the AR3 analysis period, all states except New York were able to report some measures of preponderance of care. Some states demonstrated progress from the pre-SIM baseline, while others collected baseline data on VBP arrangements that pre-date SIM Initiatives. Measurement of state progress has been hampered by the perceived complexity of preponderance measures, the difficulty health plans are having in applying measure definitions to their VBP arrangements, and concerns among private plans about disclosing proprietary information. States expected to compile more data points to evaluate progress going forward.

Despite problems with measures, interviews with payers suggested that commercial and Medicaid plans have continued expanding VBP parallel to SIM efforts with variable success. Health plans and providers cited three major factors as contributing to further VBP adoption: (1) SIM's facilitation of multi-payer dialogue and alignment, (2) new Medicaid requirements, and (3) the recognition that VBP is the future direction of Medicare.

ES.2 Status of Practice Transformation under Round 2 of the State Innovation Model Initiative

Providers reported improvements in screening for behavioral health needs and connecting patients to care. Expanding capacity in behavioral health integration preceded the SIM Initiative (often supported through state PCMH initiatives). However, providers overall indicated that upfront investments and varied supports to practices enabled by SIM had created momentum in behavioral health screening, coordination, and linkages to treatment. Rhode Island, Colorado, Connecticut, Delaware, Tennessee, and Washington cited specific improvements in one or more of these behavioral health areas. Facilitating access to data (e.g., admission, discharge, and transfer dashboards) was a practice support that accelerated the pace of behavioral health integration. Trainings and tools to help providers use their behavioral health data were also beneficial.

The main limitation to the spread of behavioral health integration in some states remains shortages in the behavioral health workforce. Stakeholders across states continued to note the general scarcity of trained behavioral health providers, especially in rural areas. In response, SIM workforce efforts focused largely on training and changing workflows to improve existing workforce efficiency. Telemedicine, psychological consultation services, and care teams also

stretched available clinical expertise. Providers welcomed these supports but recognized they were insufficient on their own to meet the demand for behavioral health within their practices.

Demand for care coordination was higher than states initially anticipated, and payment for care coordination remained a challenge for delivery transformation. Payers did not uniformly cover care coordination. In addition, rules prohibiting providers from receiving per member per month (PMPM) payments in some states from more than one payer meant that some patients within the same practice were covered, while others were not. In response, providers developed a range of strategies—including clinical protocols to manage care for specific groups of high-needs patients, limiting care coordination to patients based on insurance source, or serving patients of all payers regardless of which payers paid for coordination services. Notably, the rare providers able to secure payment to cover care coordination for all their payer populations appeared to have the fewest care coordination challenges.

The biggest achievement in health IT was additional progress on admission, discharge, and transfer alerts; exchanging additional clinical information beyond alerts and among a range of providers to improve care remained a challenge. The states that used SIM funds to advance alerts (Iowa, Michigan, Tennessee, and Rhode Island) reported that more hospitals are participating in the alert systems and more providers have access to them. As an essential factor for progress toward using a common system, these states emphasized the importance of standardization—of data fields and definitions—across providers submitting data into the information exchange system. Providers noted the benefits of alerts on patient encounters outside their walls, and consumers noted the benefits of alerts for coordinating their care when they needed hospital services.

States have sought to expand, beyond ADT alerts, the functions available through shared medical records data on common platforms to both hospitals and physician practices at points of care. Tennessee, for example, used its Care Coordination Tool for sharing information about clinical encounters other than those captured in ADT alerts. In all states, however, these efforts continue to be limited by concerns over privacy, data ownership, and ongoing costs. Stakeholders reported that it was challenging and often burdensome to adapt information sharing into clinical workflows. PCMH-participating providers described the high cost of acquiring and maintaining electronic health record systems capable of exchanging health information as a burden that threatens further advances in the use of health IT by practices.

Both providers and payers agreed that alignment on quality measurement was essential for system transformation and that important dialogues to achieve alignment progressed. States turned their focus to refining common measure sets, encouraging and supporting measure adoption by additional payer groups, ensuring data quality, and engaging in provider and public reporting activities. Commercial payers emphasized the importance of aligning quality measures to spread APM adoption and viewed alignment of quality measures

and reduction of provider burden as the highest priorities. All but three states produced provider feedback reports.

Providers described the calculation and submission of quality measures as a major burden on staff time and resources. In addition, providers suggested that provider feedback reports could be improved through timelier and more accurate data about patients. In Colorado, providers reported that practice facilitators and clinical health IT advisors helped them better understand and use their data and manage data quality issues. Health plans in Colorado and Tennessee described one-on-one meetings with practices to find solutions to identified issues. A few states worked directly with providers to address their experience with quality reporting. However, lack of timely data and discrepancies between payers' data and the data collected by states remained barriers to full engagement in the transformation process.

ES.3 Status of Population Health under Round 2 of the State Innovation Model Initiative

More than half of the states advanced their population health initiatives. Among these states, clinical and community health integration emerged as the dominant strategy for population health. Colorado, Delaware, Iowa, Michigan, Rhode Island, Washington, and Idaho made significant strides in implementing population health strategies to address community-level needs. Previously, states had focused heavily on developing community measures of health and well-being. Those efforts in Michigan, Iowa, and Rhode Island resulted in new and enhanced infrastructure to exchange data between clinical and community-based entities—which also increased the capacity of these states to address social determinants of health. These achievements in population health facilitated a core component of delivery transformation's care coordination. Navigators used social determinants of health data to identify patient needs and connect them to community resources. In this respect, the delivery transformation and population health arms of the SIM Initiative have become mutually reinforcing.

ES.4 Conclusion

States shifted from planning activities and the early phases of implementing those activities to making progress in (1) aligning commercial stakeholder interests toward payment reform, (2) advancing behavioral health integration and primary care transformation, and (3) establishing the infrastructure for population health planning and coordination. The next report, AR4, will explore state experiences related to the impact of specific strategies in each of these three areas.

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1. Introduction

State governments have the potential to accelerate statewide health care system transformation and serve as laboratories for innovative health care models. In 2015, the Center for Medicare and Medicaid Innovation (CMMI) Round 2 State Innovation Model (SIM) Initiative funded 11 Model Test states: Colorado, Connecticut, Delaware, Idaho, Iowa, Michigan, New York, Ohio, Rhode Island, Tennessee, and Washington. Model Test states' activities under the SIM Initiative fall into four major categories: (1) using policy and regulatory levers to enable or facilitate the spread of innovative health care models, (2) integrating behavioral health and population health into transformation efforts, (3) engaging a broad range of stakeholders in the transformation efforts, and (4) leveraging existing efforts to improve health care delivery and outcomes. Collectively, these activities assist states in meeting the SIM Initiative's primary objective to achieve a "preponderance of care". CMMI defines preponderance of care as³ having at least 80 percent of care in a state—calculated on the basis of population, expenditures, or practices—in delivery arrangements that use value-based payment (VBP) or alternative payment models (APMs) to incentivize better care and lower costs.⁴

All 11 states had previously received Round 1 Model Design or Pre-Test awards to work with CMMI to design State Health Care Innovation Plans (SHIPs). The SHIP delineated 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"⁵—reflecting the SIM Initiative's primary objective to move toward 80 percent of payments from all payers in the state being value based.⁶

The Model Test awards were for 4 years. The first Award Year [AY1] was meant for states to further develop the strategies embodied in their SHIPs. The last three AYs were for the states to test their respective strategies. However, some states continued to develop and refine their SIM strategies past the designated test period to meet their evolving delivery system reform goals, leading CMMI to grant state requests to postpone the start of their SIM test periods.

³ Rajkumar, R., Conway, P. H., & Tavenner, M. (2014). CMS—engaging multiple payers in payment reform. *JAMA*, 311(19), 1967–1968. doi: 10.1001/jama.2014.3703.

⁴ VBP is a strategy used by purchasers to promote the quality and value of health care services. The goal of VBP programs is to shift from pure volume-based payment, as exemplified by fee-for-service payments, to payments more closely related to health outcomes. An APM is any approach meeting the criteria established by the Centers for Medicare & Medicaid Services (CMS) that gives added incentive payments to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population. Advanced APMs are a subset of APMs that let practices earn more rewards in exchange for taking on risk related to patient outcomes. Source: CMS. (2017). APMs overview. *Quality Payment Program*. Retrieved from <https://qpp.cms.gov/apms/overview>.

⁵ Centers for Medicare & Medicaid Services (CMS). (2017). *State Innovation Models Initiative: General information*. Retrieved from <https://innovation.cms.gov/initiatives/state-innovations/>.

⁶ Rajkumar, R., Conway, P. H., & Tavenner, M. (2014). CMS—engaging multiple payers in payment reform. *JAMA*, 311(19), 1967–1968. doi: 10.1001/jama.2014.3703.

Figure 1-1 shows the updated period of performance for each Model Test state as of March 31, 2018. Three of the Round 2 Model Test states are scheduled to complete their test periods on January 31, 2019, as originally planned. The remaining eight states were granted no-cost extensions, enabling them to end their test period later than planned.

To obtain an independent federal evaluation of the Round 2 SIM Initiative, CMMI contracted with the team of RTI International and its subcontractors—National Academy for State Health Policy, The Urban Institute, The Henne Group, and Native American Management Services.

1.1 Purpose of the Year 3 Annual Report (AR3)

As the third in a series of four planned Annual Reports (ARs) and a final report, the purpose of this report is to analyze stakeholder perceptions of the changes resulting from SIM Initiative implementation. The research questions addressed in this report follow.

- What progress have the states made on SIM Initiative activities? These include
 - engaging with payers, communities, providers, and target populations to facilitate health system transformation;
 - building and establishing new payment and delivery system models;
 - integrating behavioral health and primary care;
 - enhancing health information technology;
 - aligning quality measures and reporting across multiple payers;
 - developing the workforce to support transformation; and
 - identifying key clinical or public health strategies to improve population health within new payment and delivery system models.
- How do providers working within SIM Initiative–related health care delivery and payment models describe changes in care delivery?
- How do consumers (patients) served by providers working within SIM Initiative–related health care delivery and payment models describe changes in care they receive?
- What were the key successes, challenges, and lessons learned through the SIM implementation and testing process?
- Which policy and regulatory levers are the states using to transform health care delivery systems?

Figure 1-1. Round 2 Model Test period of performance, as of March 31, 2018

Year	2015					2016					2017					2018					2019					2020													
Month	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
Model Test States																																							
Colorado	AY1					AY2					AY3					AY4																							
Connecticut	AY1					^	AY2					AY3					^	AY4																					
Delaware	AY1					AY2					AY3					AY4																							
Idaho	AY1					AY2					AY3					AY4																							
Iowa	AY1					AY2					AY3					AY4																							
Michigan	AY1					AY2					AY3					AY4																							
New York	AY1					AY2					AY3					AY4																							
Ohio	AY1					AY2					^	AY3					^	AY4					^																
Rhode Island	AY1					AY2					A3					AY2																							
Tennessee	AY1					AY2					AY3					AY4																							
Washington	AY1					AY2					AY3					AY4																							

Source: CMMI

AY = Award Year; CMMI = Center for Medicare and Medicaid Innovation.

Note: Cells shaded in orange (with ^) represent months in which there is an intra-month (e.g., mid-month) transition between AYs.

3

The evaluation team assessed the impact of the SIM Initiative in this report using qualitative data from document reviews, participation in meetings by phone, key stakeholder interviews, and provider and consumer focus groups. The assessment covered (1) progress the 11 states made during the AR3 analysis period in using levers to transform health care delivery and (2) indications regarding whether the transformed health care delivery systems are changing quality of care, care coordination, health care utilization and expenditures, and population health. This report analyzes data collected between May 1, 2017, and March 31, 2018 (the AR3 analysis period). Future reports will include analyses of quantitative outcome data on statewide impacts on health care use, expenditures, coordination, and quality and model-specific analyses, data for which were unavailable for this report.

1.2 Organization of the Year 3 Annual Report

The remainder of this chapter provides a brief overview of the data and the methods used to conduct the qualitative data collection and analyses (*Section 1.3*) and the limitations of this report (*Section 1.4*). Chapter 2 provides the main cross-state evaluation findings of the Round 2 SIM Initiative, comparing stakeholder perceptions of the differences in health care delivery resulting from the SIM Initiative. The synthesized findings offer insights into how health care is changing in states with Round 2 SIM Initiative Model Test awards. Finally, Chapter 3 contains conclusions that may be drawn from the evaluation findings. The evaluation team reports state-specific findings for each of the 11 states in *Appendixes A through K*.

1.3 Qualitative Evaluation Data Collection and Analysis Methods

The evaluation team for each Round 2 Model Test state collected qualitative data throughout the AR3 analysis period to understand how states implemented their SIM Initiatives and the successes and challenges they faced. Evaluators monitored state activities by conducting site visits with stakeholder interviews and focus groups, participating in meetings by phone with state and federal SIM program staff, and reviewing implementation-related documents. Evaluators then used coded qualitative data triangulated from multiple sources to arrive at the findings presented in this report. High-level descriptions of the site visit data collection processes and qualitative analysis methods follow (see *Appendix L* for more detail).

1.3.1 Site visit data collection

In February and March 2018, the evaluation team conducted in-person site visits comprising stakeholder interviews and focus groups with all 11 Round 2 Model Test states. Site visits enabled the evaluation team to explore implementation progress, challenges, and lessons learned; significant administrative or program changes; and perceived effects on implementation and impact outcomes.

Stakeholder interviews

State officials, payers, providers, consumer advocates, and other informants shared their opinions and experiences with SIM-related reforms during stakeholder interviews. The evaluation team conducted 202 interviews in total, averaging 18 interviews per Model Test state (*Table 1-1*). Pairs of state evaluators—one interviewer and one note taker—conducted the interviews using semi-structured protocols with questions preselected for each stakeholder group. The interviews focused on overall implementation progress, stakeholder engagement, delivery transformation and payment reform, health information technology, quality measurement and reporting, preponderance of care, population health, and the sustainability of SIM Initiative activities.

Table 1-1. Round 2 Model Test state interviews, by state and stakeholder type

State	State officials	Payers	Providers	Consumer advocates	Other	Total
Colorado	6	2	6	2	3	19
Connecticut	6	2	4	2	0	14
Delaware	7	3	4	3	0	17
Idaho	5	2	8	1	1	17
Iowa	9	4	4	2	0	19
Michigan	5	1	12	4	0	22
New York	7	5	2	1	7	22
Ohio	3	4	4	3	0	14
Rhode Island	10	2	4	2	0	18
Tennessee	12	4	6	0	1	23
Washington	8	4	5	1	2	20
Total	78	33	59	21	14	205

SIM = State Innovation Model.

Note: The total exceeds 202 because three interviews were conducted with multiple interviewees from different stakeholder groups. “Other” interviewees typically include contractors supporting SIM implementation and public health professionals.

Provider and consumer focus groups

Evaluators conducted a total of 39 focus groups with consumers and providers separately to solicit their perceptions of, and experiences with, SIM Initiative reforms. The team recruited focus group participants from the populations most likely to be affected by the delivery and payment reforms pursued in each state. In all states except Colorado, Connecticut, and New

York,⁷ the evaluation team conducted two focus groups with consumers and two with providers. The team strove to capture a diverse set of perspectives by recruiting participants, to the maximum extent feasible, from multiple locations and with different health care experiences.

1.3.2 State evaluation and program call data collection

Evaluators captured additional information from Model Test states by participating in SIM Initiative calls. Team members attended biweekly program calls with the states' CMMI project officers and SIM technical assistance teams to hear planning and implementation progress updates. State evaluation teams also held a monthly evaluation call with each state, except Tennessee, to discuss the data needed for the federal evaluation and gather information about state planning, implementation, testing, and evaluation activities—including successes, challenges, and lessons learned.⁸

1.3.3 Document review data collection

Evaluators reviewed the following types of documents for information on SIM Initiative implementation:

- State profiles from the State Health Access Data Assistance Center
- Quarterly reports and ARs
- State-reported model and payer participation and state health care landscape metrics reported through the CMS Salesforce portal
- Stakeholder and work group meeting notes
- Information released through states' SIM Web sites, SIM Initiative Listservs, press releases, and news articles
- Other materials states made publicly accessible or provided to the evaluation team.

Evaluators abstracted relevant information from the documents into structured templates organized by topic.

1.3.4 Qualitative data analysis

Evaluators analyzed the qualitative data in two steps. First, analysts used NVivo analysis software to code qualitative data from disparate sources into broad substantive areas relevant to the SIM Initiative, including stakeholder engagement, delivery transformation, and payment

⁷ Evaluators cancelled the second provider group in Connecticut because an insufficient number of providers met the eligibility criteria. Consumer focus groups were not conducted in Colorado because the evaluation team could not obtain recruitment lists in time for the site visits. Consumer focus groups were not conducted in New York because consumers had not yet enrolled in the Advanced Primary Care model.

⁸ In Tennessee, in lieu of a monthly evaluation call, the evaluation team instead shared topics for discussion and raised questions on the biweekly program calls.

models (see *Appendix L* for more information). The team developed the initial codebook constructs using the qualitative protocols, evaluation research questions, and early evaluation findings. After piloting the initial codes using a subset of qualitative data, analysts processed the remaining files. The team then used NVivo to output reports grouping the coded data by topic, state, and source.

Next, the evaluation team used NVivo reports to address the evaluation research questions by identifying themes within and across topic areas. State evaluation team members focused specifically on issues relevant within each Model Test state, enabling them to prepare appendix chapters reflecting the unique contexts of the state SIM Initiatives. Team members arrived at the reported conclusions using an inductive approach, by reviewing code reports, identifying recurring themes within and across substantive areas, and then refining initial impressions through group discussion and iterative data review. Information was triangulated across different sources and stakeholders to assemble a robust evidence base and explore various perspectives. Findings from previous evaluation years enabled the teams to track key developments over time.

Experts specializing in substantive areas relevant to the broader SIM Initiative worked together to formulate findings across the 11 Model Test states. These experts first used NVivo reports to prepare preliminary conclusions for team consideration relevant to their substantive areas. State evaluation team members then helped the experts refine their impressions, by both offering additional information to support the preliminary conclusions and encouraging experts to reconsider findings to fully capture states' experiences. Biweekly meetings and a day-long workshop enabled the substantive experts to work across their particular areas—thinking critically about how findings relevant to one area related to other areas, understanding the relationships among different elements of the SIM Initiative, and deriving the findings presented in this report.

1.4 Limitations

Readers should keep three major limitations in mind when reviewing this report. First, the SIM Initiative and its implementation are dynamic. Thus, many of the analysis results, initiative designs, and progress may have changed between the end of the AR3 analysis period—March 31, 2018—and the report's release. Thus, this report is an interim assessment of the SIM Initiative—the third in a series of four ARs and a final report, as noted.

Second, a major data source for this report consisted of responses the evaluation team collected during its key informant telephone interviews and consumer and provider focus groups. Although the interviewees represented a variety of stakeholders and viewpoints, these may not be representative of the populations in the Round 2 Model Test states, leaving open the

possibility of bias in the results based on the qualitative data. Furthermore, the accuracy of the responses received from the interviewees cannot be guaranteed.

Third, as with the previous two ARs, the timing of this report prevented the inclusion of any claims-based analyses of care delivery, coordination of care, quality of care, utilization, and expenditures because of the unavailability of Medicaid claims data. As claims data become available, future reports will include impact analyses using claims-based outcome measures.

2. State Innovation Model Initiative in Model Test States: Cross-State Findings May 2017–March 2018

This chapter provides the main cross-state evaluation findings related to progress in the adoption of value-based payment (VBP) and toward delivery transformation, as of the end of March 2018, by the 11 Model Test states participating in Round 2 of the SIM Initiative. The progress discussed in the chapter covers three major areas: payment reform, health care delivery transformation, and population health. As part of the discussion of payment reform, state documentation of progress toward preponderance of care under VBP⁹ is reviewed. The chapter also describes actions states took to sustain SIM-related reform after the end of the SIM Initiative. The concluding section discusses the policy and practice implications of the evaluation findings, for states and for CMMI, going forward.

By the end of March 2018, states had reached major implementation milestones in SIM-funded payment and delivery transformation initiatives and initiated population health activities in communities. *Table 2-1* summarizes key accomplishments by SIM Round 2 states during the AR3 analysis period, beginning May 1, 2017, and ending March 31, 2018 (an 11-month period). Accomplishments are grouped into three categories: payment reform, delivery transformation, and population health. The last column in *Table 2-1* describes the major challenges still confronting each state at the end of the AR3 analysis period that need to be overcome to expand alternative payment models (APMs), further delivery transformation or improve population health.

As reported in AR2, SIM activities were primarily focused, with few exceptions, on driving delivery transformation among Medicaid providers and expanding VBP contracts for Medicaid and public employee sectors. Prior to May 2017, states made minor adjustments to reduce the burden on providers participating in both a Medicaid patient-centered medical home (PCMH) and Medicare’s newest PCMH model, Comprehensive Primary Care Plus (CPC+). States also continued dialogue between payers, including commercial plans in some cases, on the degree to which VBP designs and methods should be coordinated (aligned) to minimize provider burden. By the spring of 2017, many states realized that actions to date were insufficient to spread VBP adoption because of ongoing payer and provider concerns. During the AR3 analysis period, some states in response made mid-course corrections, leveraged state procurement opportunities, or adopted legislation to spur VBP contracting by commercial plans and in the public employee sector.

⁹ Achieving preponderance of care, as CMMI defines the concept for the SIM Initiative, refers to a state having 80 percent of people, payments, or providers subject to VBPs, as measured by the four CMS Learning and Action Network (LAN) categories. (CMS. [2016]. *Health Care Payment Learning and Action Network*. Accessible at <https://innovation.cms.gov/initiatives/Health-Care-Payment-Learning-and-Action-Network/>).

Table 2-1. Highlights of progress by State Innovation Model Round 2 Model Test states and major challenges remaining, May 1, 2017–March 31, 2018

State	Payment reform	Delivery transformation	Population health	Major challenges remaining
Colorado	<ul style="list-style-type: none"> Convened provider-payer symposiums to discuss outstanding concerns. 	<ul style="list-style-type: none"> An additional 154 primary care practices joined practice transformation efforts. Integrated most SIM-participating payer data into the claims aggregator tool. HIEs began building an eCQM reporting platform. 	<ul style="list-style-type: none"> Launched campaigns to reduce stigma and raise awareness of mental health. Regional health connectors implemented community health initiatives. 	<ul style="list-style-type: none"> Difficulties integrating primary care and BH and ensuring information sharing between providers Lack of a standardized VBP across payers for BH integration and practice transformation Shortage of BH providers
Connecticut	<ul style="list-style-type: none"> Recruited 11 employers to receive TA to participate in value-based insurance design. 	<ul style="list-style-type: none"> Launched a Web site for virtual CHW training. 	<ul style="list-style-type: none"> Population health activities were not part of Connecticut’s SIM Initiative. 	<ul style="list-style-type: none"> Weak health IT infrastructure. Limited inter-agency coordination Low payer buy-in resulting from lack of demonstrated ROI
Delaware	<ul style="list-style-type: none"> VBP objectives for state employee benefits became effective. New Medicaid VBP targets effective 01/01/2018. 	<ul style="list-style-type: none"> New legislation mandates payers participating in the state employee benefit marketplace and Medicaid must submit claims to the APCD. 	<ul style="list-style-type: none"> Launched three Healthy Neighborhoods lifestyle initiatives focused on opioid awareness, maternal and child health, and diabetes and obesity reduction. 	<ul style="list-style-type: none"> Provider costs for reporting, data submissions, and PCMH certification Low participation by small practices in care transformation or VBP

(continued)

Table 2-1. Highlights of progress by State Innovation Model Round 2 Model Test states and major challenges remaining, May 1, 2017–March 31, 2018 (continued)

State	Payment reform	Delivery transformation	Population health	Major challenges remaining
Iowa	<ul style="list-style-type: none"> Two Medicaid MCOs negotiated VBP contracts with ACOs effective in 2018, based on a state template. Added requirements in Medicaid MCO contracts toward aligning with MACRA requirements for Other Payer Advanced APMs. 	<ul style="list-style-type: none"> Increased participation in SWAN to roughly half of all hospitals. 	<ul style="list-style-type: none"> C3 teams used ADT feeds to reduce readmissions, ER visits, and diabetes within targeted communities. Developed screening tools for SDoH. 	<ul style="list-style-type: none"> Lack of agreement from Medicaid managed care plans about state-preferred VBP design choices Low provider use of SWAN alerts despite wider access
Idaho	<ul style="list-style-type: none"> New mandated payment models were not part of Idaho’s SIM activities. Engaged health plans on VBP through regular workgroup meetings. Collected data from payers on the current reach of VBP. Collaborated with Medicaid agency to ensure their new payment models are aligned with the SIM Initiative. 	<ul style="list-style-type: none"> Established bidirectional connections to HIE for 69 PCMH cohort clinics. Two clinic cohorts received TA for transformation. Forty-eight CHWs received training. Established peer-to-peer learning for PCMH cohort clinics. Funded 12 telemedicine projects. Established 10 CHEMS programs. Began Project ECHO for treatment of opioid addiction. 	<ul style="list-style-type: none"> RCs developed strategic plans to address community specific needs (e.g., opioids). RCs developed medical neighborhoods to better connect primary care and social services. Implemented activities to impact access to health care and to diabetes, tobacco, and obesity interventions. 	<ul style="list-style-type: none"> Lack of payer alignment in VBP Shortages of primary care and BH providers Delay in common health IT infrastructure The state’s current PCMH model has not significantly influenced APMs with private payers.

(continued)

Table 2-1. Highlights of progress by State Innovation Model Round 2 Model Test states and major challenges remaining, May 1, 2017–March 31, 2018 (continued)

State	Payment reform	Delivery transformation	Population health	Major challenges remaining
Michigan	<ul style="list-style-type: none"> • Surveyed payers on the reach of APMs to plan next steps in establishing payment models. • Engaged health plans on APM issues through regular workgroup meetings. 	<ul style="list-style-type: none"> • Practices onboarded to state HIE and receiving ADT alerts. • PCMH practices and CHIRs received TA via Webinars, calls, and in-person summits. 	<ul style="list-style-type: none"> • CHIRs implemented screening tools for SDoH and strategies to reduce ER utilization. • CHIRs established “hubs” to connect clinical care to social services. 	<ul style="list-style-type: none"> • Lack of payer alignment in VBP
New York	<ul style="list-style-type: none"> • Formed Regional Oversight Management Committees to foster region-specific multi-payer payment models to support practices that adopt the PCMH model of care. • Replaced the state’s medical home model with NCQA’s NYS PCMH model to entice payer participation and simplify provider choices. 	<ul style="list-style-type: none"> • Nearly 750 practices enrolled with TA contractors, up from 100. • Executed four Project ECHO contracts. • Approved three contracts for rural residency programs. • Distributed multi-payer “scorecard” quality measure report to APC practices. • Launched mini-grants to help practices connect to an HIE. 	<ul style="list-style-type: none"> • Communicated with CMS and CDC to gain approval of Linking Intervention For Total Population Health awards, which will fund population health efforts in particular areas. 	<ul style="list-style-type: none"> • Payers had not yet committed to offering practices new payments through the SIM Initiative

(continued)

Table 2-1. Highlights of progress by State Innovation Model Round 2 Model Test states and major challenges remaining, May 1, 2017–March 31, 2018 (continued)

State	Payment reform	Delivery transformation	Population health	Major challenges remaining
Ohio	<ul style="list-style-type: none"> Increased EOC reporting to 43 episodes in Medicaid Issued financial incentives for 3 EOCs. 	<ul style="list-style-type: none"> Increased OH CPC provider enrollment from 111 to 161 practices. Distributed referral reports to OH CPC and principal accountable providers. Disseminated consolidated EOC reports by payer. Added new school health initiative to the SIM Initiative, intended to facilitate patient engagement and to be linked to OH CPC. 	<ul style="list-style-type: none"> Continued to align measures with population health priorities as new episodes developed. 	<ul style="list-style-type: none"> Expansion of OH CPC delayed until 2019 because of legislated funding reductions Need to engage small and rural practices in OH CPC when eligibility expands in 2019 Limited awareness among some providers of the EOC initiative Financial incentives from Medicaid in the EOC program may not be sufficient to support practice transformation and care coordination
Rhode Island	<ul style="list-style-type: none"> Maintained the APM target required by all plans at the 2018 level for calendar year 2019. 	<ul style="list-style-type: none"> Helped finance the transformation of nine primary care practices into certified PCMH-Kids. Provided >400 psychiatric consults since December 2016. Care Management Dashboard became operational in seven CMHCs. Completed SBIRT training for 700 professionals. 	<ul style="list-style-type: none"> Planned a unified social services database to help providers address patients' needs. Launched three initiatives addressing high-risk patient identification; tobacco assessment, referral and treatment; and statewide BMI data collection. 	<ul style="list-style-type: none"> Payer reimbursement not yet adapted to integrating BH, posing challenges to providers working in an integrated practice.

(continued)

Table 2-1. Highlights of progress by State Innovation Model Round 2 Model states and major challenges remaining, May 1, 2017–March 31, 2018 (continued)

State	Payment	Delivery transformation	Population health	Major challenges remaining
Tennessee	<ul style="list-style-type: none"> Removed downside risk and retained upside risk with gain share for commercial EOC providers. Required EOCs in state employee plans but left provider participation voluntary. Continued higher payments in its Health Home initiative, HealthLink, in response to provider complaints. Revised nursing facility prospective per diem payment structure in rulemaking. 	<ul style="list-style-type: none"> Expanded ADT submissions to the CCT to roughly two thirds of Tennessee hospitals. Activated CCT to send ADT feeds to participating practices. Streamlined data reporting for LTSS providers. Continued TA for Enhanced Respiratory Care, with support from the Enhanced Respiratory Care vendor and MCOs. Payers facilitated peer-to-peer learning sessions and Webinars around the EOC model. Community college programs to train long-term care workforce were funded through the state lottery. 	<ul style="list-style-type: none"> Twelve Vital Signs measures were finalized and sub-measures were developed for scoreboard of statewide population health. Began building interactive Web database of Vital Signs quality improvement recourses. 	<ul style="list-style-type: none"> Participation in EOCs by commercial payers remains low.

(continued)

Table 2-1. Highlights of progress by State Innovation Model Round 2 Model Test states and major challenges remaining, May 1, 2017-March 31, 2018 (continued)

State	Payment reform	Delivery transformation	Population health	Major challenges remaining
Washington	<ul style="list-style-type: none"> Moved 16 FQHCs to PMPM reimbursement for Medicaid MCO enrollees. Revised the proposed critical access hospital payment model to enable other rural providers to participate in rural multi-payer pilot. Required third-party administrator for Uniform Medical Plan offerings through the Public Employee Benefits portfolio to offer similar value-based options in their private business. 	<ul style="list-style-type: none"> Expanded Medicaid MCO integration of physical health and BH into a second multi-county region and launched procurement process to secure contractors for the remaining regions. Improved Analytics, Interoperability, and Measurement’s Healthier Washington data dashboards to better support ACH planning. Practice Transformation Support Hub enrolled more than 150 practices in TA. ACHs led peer learning calls. 	<ul style="list-style-type: none"> ACHs implemented community-based approaches to address opioid abuse. Enhanced linkages between the diabetes care and prevention initiative under the oversight of the DOH and projects being conducted in the ACHs. 	<ul style="list-style-type: none"> Slow spread of VBP uptake among commercial payers Negotiation with Medicare on new alternative payment arrangements to support rural delivery systems Data challenges delaying two provider networks’ use of multi-payer data to manage patient care. The Washington Health Workforce Sentinel Network Survey identified shortages of registered nurses and medical assistants.

ACH = Accountable Community of Health; ACN = Accountable Care Network; ACO = accountable care organization; ADT = admission, discharge, and transfer; APC = Advanced Primary Care; APCD = all-payer claims database; APM = alternative payment model; BH = behavioral health; BMI = body mass index; C3 = Community and Clinical Care initiative (formerly Community Care Coalition); CCT = care coordination tool; CDC = Centers for Disease Control and Prevention; CHEMS = Community Health Emergency Medical Services; CHIP = Children’s Health Insurance Program; CHIR = Community Health Innovation Region; CHW = community health worker; CMHC = community mental health center; CMS = Centers for Medicare & Medicaid Services; DOH = Department of Health; ECHO = Extension for Community Healthcare Outcomes; eCQM = electronic clinical quality measure; EOC = episode of care; ER = emergency room; FQHC = Federally Qualified Health Center; health IT = health information technology; HIE = health information exchange; LTSS = long-term services and supports; MACRA = Medicare Access and CHIP Reauthorization Act of 2015; MCO = managed care organization; NCQA = National Committee for Quality Assurance; NYS PCMH = New York State Patient-Centered Medical Home; OH CPC = Ohio Comprehensive Primary Care; PCMH = patient-centered medical home; PMPM = per member per month; RC = Regional Health Collaborative; ROI = return on investment; SBIRT = Screening, Brief Intervention, and Referral to Treatment; SDoH = social determinants of health; SIM = State Innovation Model; SWAN = Statewide Alert Notification; TA = technical assistance; VBP = value-based payment.

Prior to May 2017, many Round 2 Model Test states had enrolled practices and health centers in technical assistance (TA) programs, behavioral health integration, and PCMH initiatives. Some states also had fixed design flaws and technical problems affecting common health information technology (health IT) infrastructure and worked to connect a greater number of providers to health information exchanges and quality reporting tools. In addition, states focused on identifying and executing strategies to overcome major barriers to the spread of VBP, delivery transformation, and population health. To support population health objectives, community-based entities had finalized operational plans and established connections with primary care settings to facilitate clinical-to-community linkage.

These efforts paid off beginning May 2017, as states made significant progress during the AR3 period in the following ways:

- Practices achieved new PCMH milestones and expanded care coordination and referral networks.
- States achieved widespread provider use of health IT infrastructure and analytic tools.
- More providers described successfully integrating health IT and feedback reports into patient care and work flow to better meet their patients' needs.
- Commercial payers became increasingly willing to make use of common measure sets and support practices in transformation efforts.
- States spurred expansion of VBP contracting in Medicaid and public employee markets and, to a lesser extent, commercial markets.
- States launched SIM-funded campaigns to promote population health and strengthened linkage to clinical settings.

States made less progress and faced greater challenges addressing:

- Low participation by small, independent, and rural practices in delivery transformation and in VBP contracts
- Acute workforce shortages for behavioral health providers and community health workers (CHWs)
- Sustainable payment streams for CHW and telehealth services
- A mismatch between the infrastructures supporting population health objectives and local needs.

This chapter synthesizes and explains the choices states made to confront a range of barriers to spreading VBP adoption, delivery transformation, and major factors hindering progress based on stakeholder feedback. Interviews with payers for the AR3 analysis period explored in depth the health insurance and provider market barriers that commercial and Medicaid health plans have confronted when seeking new VBP contracts with their providers. At

the time of interviews in the spring of 2018, stakeholders had accumulated enough exposure to models initiated under the SIM Initiative and to VBP generally (sometimes a decade of experience) to provide critical feedback and insights into the factors explaining progress toward SIM objectives. In addition, stakeholders were better positioned to assess the risks posed by outstanding barriers. In rare cases, feedback came from only one or two states; these cases are only included in the discussion when they provide important lessons for application in other states.

2.1 What Progress Have States Made and What Barriers Do They Face Implementing Value-Based Payment Models?

KEY FINDINGS



Progress

- Five states that approached multi-payer collaboration through voluntary engagement added VBP targets, guidelines, or requirements for payers to encourage the spread of VBP contracting.
- Several states loosened provider requirements, established a common PCMH model, or planned coordinated multi-payer action to boost PCMH adoption and support VBP adoption, especially among small and rural practices.
- Several states addressed the lack of adequate pay for patient navigation and care coordination by considering changes to billing codes and incentive payments.

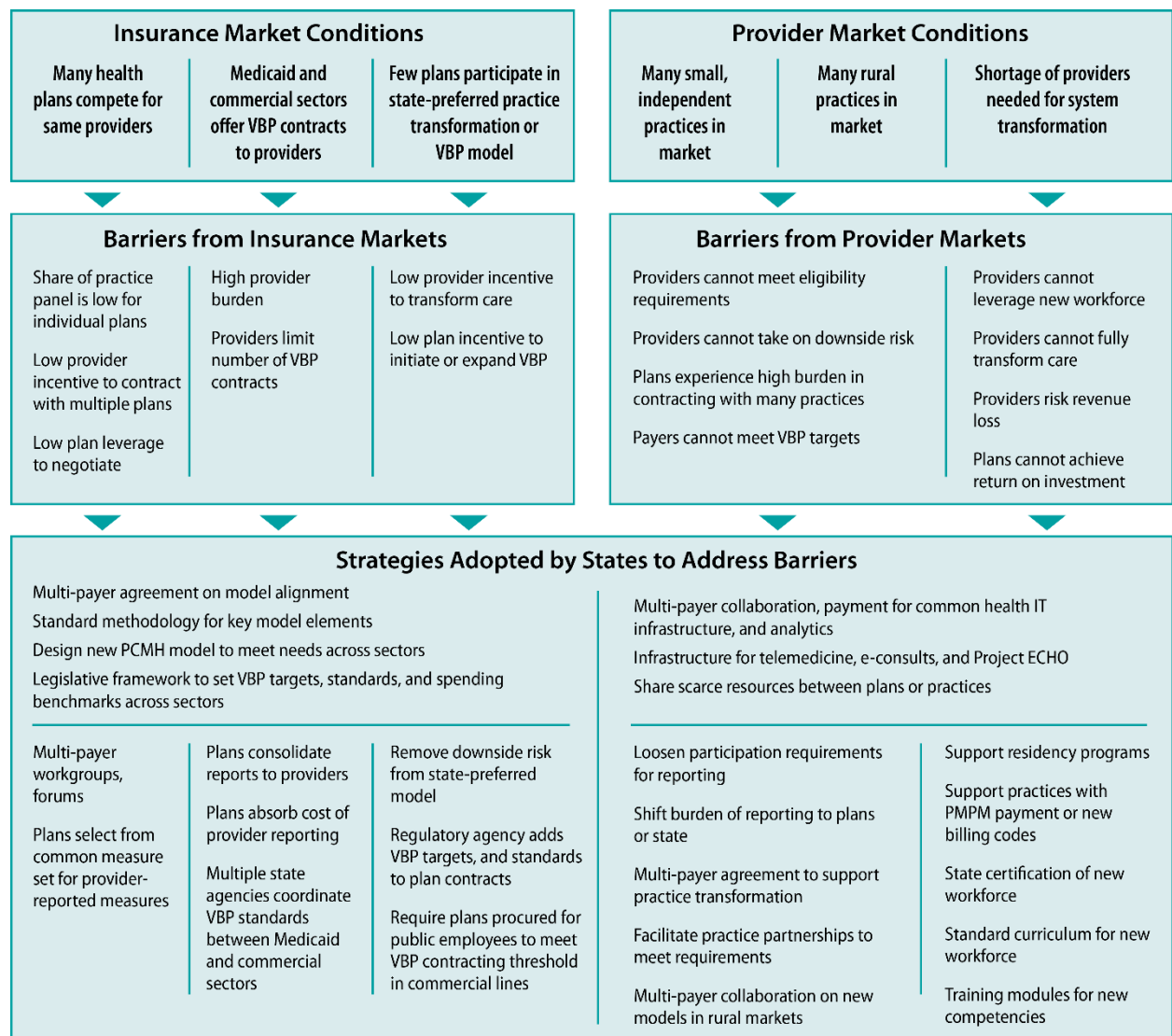
Barriers

- Payers reported that the presence of many small, independent practices in their networks and low negotiating leverage with providers posed the greatest challenge to spreading VBP and adding two-sided risk to VBP.
- Providers in some states described disincentives to continue participating in VBP, such as inadequate PMPM payment, cumbersome prior authorization, step therapy requirements, or lack of reimbursement for selected services.
- Providers across states identified the need to find sustainable payment streams to implement and maintain behavioral health integration.

States' abilities to identify and implement strategies that help health plans succeed will be an important determinant of widespread VBP adoption. Interviews with health plans and providers for this year's report provide stronger evidence that reported slow progress in the spread of VBP contracting by Medicaid and commercial health plans should not be attributed (solely) to individual payers' reluctance to collaborate with states on VBP contracting or strategic decisions to remain on the sidelines or keep their contracting arrangements private—a finding that was stressed in AR2. Rather, payers reported that the market conditions they face contribute to their success or failure expanding VBP contracting.

To assist in our review of strategies that states applied during the AR3 period, *Figure 2-1* depicts selected market conditions frequently reported across SIM Model Test states as problematic; the barriers emerging from those conditions (as described by stakeholders); and the range of strategies states have chosen or plan to address those barriers during the period covered by this report. Some approaches have potential to address more than one barrier. *Figure 2-1* includes several SIM strategies not primarily designed to address the barriers listed but that appear to some stakeholders to have spillover effects on these barriers. Strategies designed for delivery transformation initiatives (e.g., provider shortage) are discussed in *Section 2.3*.

Figure 2-1. State strategies used by SIM Round 2 states to address barriers emerging from insurance and provider market conditions



ECHO = Extension for Community Healthcare Outcomes; health IT = health information technology; PCMH = patient-centered medical home; PMPM = per member per month; VBP = value-based payment.

Following the flow of this figure, we first discuss market conditions that continue to create a common set of barriers and then describe strategies that states identified, planned, or implemented to overcome these barriers and expand payment reforms to more payers and providers during the period covered in this report. The discussion in this report focuses on synthesizing stakeholder perspectives on the likelihood that strategies will overcome barriers as intended. It is too early to derive conclusions about the effectiveness of the strategies. AR4 will explore stakeholder experiences related to the impact of specific strategies.

2.1.1 Barriers emerging from market conditions

Progress by individual health plans to spread VBP is hindered by low VBP participation among small, independent practices.

As reported in AR2, SIM Initiative officials were acutely aware that small, independent practices have more difficulty meeting requirements for participation in PCMH models, submitting required quality measures, and meeting minimum patient numbers to support reliable measurement. What became clearer through interviews conducted with health plans in the spring of 2018 is that each plan’s ability to spread VBP

contracting through their own provider networks is especially problematic in markets heavily dominated by large numbers of small, independent practices, where provider market fragmentation is an issue. Most states have substate markets that meet these conditions, and thus, the low participation of such practices in PCMH and VBP contracts remains a barrier to the spread of APMs and delivery transformation.

“Most of our providers are in small practice arrangements. Even if they’re part of an ACO, they are still an independent practice. The infrastructure investments are very difficult and then things like supporting care coordination or working through social determinants of health may be difficult for the smaller practices. So, figuring out how to create shared resources among those practices is a big part of trying to help with that.”

—Delaware state official

Health plans interviewed in most states¹⁰ described executing contracts for hundreds of small, independent practices to fill out provider networks. While not explicitly cited by plans as a barrier to spreading VBP, the sheer number of small practices individual plans must negotiate

“Although the majority of providers are in integrated systems, that leaves many independent family practices and independent chiropractors with whom to negotiate contracts.”

—Iowa health plan

with may help to explain the limited spread of VBP described by some individual plans. Some plans in Iowa and New York described offering a single, non-negotiable, standard VBP contract for all small practices, allowing plans to focus negotiations on the larger providers. This strategy is likely an industry practice across states. Health plans described standard contracts designed to make participation easier for small practices. Because these standard contracts must work for so many small practices, it is not surprising that the VBP provisions described were

¹⁰ Iowa, Idaho, Michigan, New York, Ohio, Rhode Island, and Washington

minimal, typically enhanced fee-for-service (FFS) contracts with bonuses or set-asides for reaching quality performance thresholds.

Competition among many health plans for the same providers constrains most health plans' negotiating leverage with providers, as in previous years. The market conditions payers described as resulting in low payer participation in VBP arise in fragmented substate markets, where no health plan is dominant or where many health plans compete to recruit providers to their network. In such markets, practices lack incentives to enter into value-based contracts when the number of patients in their panel covered by any given health plan is small. Even larger practices may not have enough patients attributed to certain health plans to meet participation requirements or make participation worthwhile. For some payers, the problem of low practice panel shares might extend throughout their provider network.

The same market dynamics that have inhibited VBP uptake by providers continue to limit the assumption of negative risk by providers, known as two-sided risk contracts.¹¹ In markets where many plans compete to attract providers to their networks, health plan representatives interviewed described practices that had enough leverage to weigh the burden of contract requirements against the potential revenue gains and risk offered by different plans, and choose to enter VBP contracts with just one or two of their largest payers. As a result, only the largest plans would have enough market power to shift risk to providers.

The interest among states and health plans to place risk onto providers has led to a discordance in many markets between the types of VBP contracts offered by payers and the contract types providers are willing and able to negotiate. This discordance was reported in more than half the Model Test states and was described as a contributing factor to both the limited uptake of VBP contracts by providers and slow progress toward applying two-sided risk in VBP arrangements. Moreover, the same challenges that inhibit small, independent practices from participating in VBP contracts also limit practice capacity to assume risk. Small practices are unable to manage the risk of lost revenue in two-sided risk contracts.

2.1.2 State strategies to address low provider and payer participation

Most of the barriers emerging from market conditions led to either low provider participation, low payer participation, or both. To overcome low provider and payer participation, states tried three major approaches: (1) adapting SIM-supported payment models, (2) facilitating multi-payer coordinated action, and (3) adding VBP targets or requirements through procurement or other mechanisms.

¹¹ Two-sided risk is a payment arrangement between a payer and provider in which the provider becomes responsible for expenditures that exceed a target price (downside risk) and receives the opportunity to share in any savings generated (upside risk) during the performance period.

Several states adapted SIM-supported payment models to encourage payer participation in state-preferred PCMH or VBP models. New York and Tennessee made major changes to payment models. In Tennessee, to make the model more palatable to providers and thus, reduce payer opposition, the Employee Benefits Administration dropped mandatory participation in EOCs for providers contracting with state employee health plans and removed downside risk. The same changes were made for commercial markets, where EOC implementation was initially planned to include downside risk with a mandate for provider participation. Largely to appeal to commercial payers, New York abandoned its PCMH model (APC) for a new model developed by NCQA specifically for New York, called NYS PCMH. Unlike the APC model, NYS PCMH carries NCQA recognition, a standard important for commercial payers. NYS PCMH also meets the requirements of the Medicaid Delivery System Reform Incentive Payment waiver, as was the case with the APC model. The transition to a nationally recognized PCMH model was enthusiastically endorsed by payers, providers, and APC TA vendors.

Other states hoped to expand VBP participation through minor adjustments to core model requirements. Michigan removed custom language from its existing PCMH program to mirror the requirements for CPC+, thus easing participation in the state PCMH model for CPC+ practices. The Ohio and Colorado SIM Initiatives had already taken similar steps to align their state PCMH and SIM participation requirements, respectively, with Medicare CPC+. Colorado began payer-provider symposiums to better coordinate actions between payers and providers and identify outstanding concerns. Providers wanted more coordination among payers because existing plan variations—in both the form and size of the financial support for practice transformation—did not yield enough clarity for informed provider decisions. The resulting uncertainty around revenue gains has limited the investments providers were willing to make. SIM officials in Michigan expressed interest in developing a modified PCMH model for nonparticipating practices (as reported to evaluators in November 2017) but did not finalize these plans as of the writing of this report.

Three states planned for coordinated multi-payer action to help small independent or rural practices participate in PCMH or VBP, but effective solutions had yet to materialize. Three states worked toward new strategies that aim to help rural practices or small independent practices (not necessarily rural) participate in practice transformation and VBP contracts. With SIM funds to support planning and convening, state officials facilitated formal and informal agreements among payers. Washington’s Rural Multi-Payer Model was designed as a pathway to identify multi-payer solutions for providers in rural areas and to facilitate negotiations with CMS about including Medicare in these solutions. Primary care, including rural health clinics (RHCs), were added to this initiative in the AR3 analysis period, but a preferred payment model has yet to be designed. In New York, state officials convene regional multi-payer committees as part of the SIM Initiative. In the Capital/Hudson Valley region,

several commercial payers identified a list of small independent practices that had not engaged in any VBP contracting and plan to communicate a coordinated message promising financial support for practices achieving the new NCQA NYS PCMH recognition. The promise of multi-plan support was expected to benefit payers having difficulty penetrating practices with low numbers of patients insured by any particular payer. The New York City region was planning the same strategy. Ohio planned to allow the formation of partnerships among small practices to jointly qualify for shared savings starting in 2019. Any impact of New York's and Ohio's strategies on provider VBP participation could become evident in later years.

Five states that had approached multi-payer collaboration through voluntary engagement established targets, guidelines, and/or requirements for payers to hasten the spread of VBP contracting. In most states, commercial and state employee plans had taken only small steps to implement and align VBP contracting by May 2017. While slow VBP progress in commercial and public employee insurance markets appeared to be partly attributable to market conditions, as described at the start of this section, the voluntary nature of engagement in multi-payer collaboration and alignment efforts might be another contributing factor. Decisions to use prescriptive levers and offer guidelines reflected states' growing recognition that simply encouraging voluntary engagement was not enough to move the payer community as a whole toward VBP contracting.

“So DFS [Department of Financial Services, New York’s commercial insurance regulatory authority] now takes a lead role and a stronger role at the meetings, because they are the rate setter under the prior approval model, and they’ve got a lot of leverage in terms of while it’s still voluntary, becomes a little bit different in terms of that relationship when you’re sitting at the table and your regulator is sitting there trying to get you to participate.... Now with the DFS at the table and some of the discussions about MLR [Medical Loss Ratio], it allows DFS to clarify or provide more guidance to the plans about how they would view that funding in a rate application as an example.”

—New York commercial payer

In the AR3 analysis period, Delaware, Michigan, New York, Tennessee, and Washington, while keeping VBP adoption voluntary, added new VBP targets (either through the SIM Initiative or outside of it) and, in some cases, new guidance or requirements under procurement levers to encourage payer participation (*Table 2-2*). In most cases, the changes were accompanied by collaborative forums or one-on-one meetings between regulators and payers. Michigan added targets and performance incentive pools to Medicaid managed care contracts to move provider contracts from Learning Action Network (LAN) Category 2 to Category 3¹² while

¹² The APM Framework set forth by the Health Care Payment LAN, a CMS initiative, refined a four-category classification scheme for payment models: FFS with no link to payment quality (LAN Category 1), FFS with a link of payment to quality and value (Category 2), APMS built on FFS architecture (Category 3), and population-based payment (Category 4). For more detail, see <https://innovation.cms.gov/initiatives/Health-Care-Payment-Learning-and-Action-Network/>

Table 2-2. State strategies for states that set value-based payment targets, requirements or guidance on selected payers, May 1, 2017–March 31, 2018

State	State action	Supplemental state activities	Intended impact
DE	<ul style="list-style-type: none"> Added targets to Medicaid MCO contracts for the percentage of spend under VBP. Required care coordination payments to providers in Medicaid MCO contracts. VBP objectives for state employee benefits became effective July 1, 2017. 	<ul style="list-style-type: none"> Procured a vendor to assess readiness of payers and providers for VBP and help the state refine payment models and purchasing strategies. 	<ul style="list-style-type: none"> Expansion of VBP contracting in Medicaid and state employee pool.
MI	<ul style="list-style-type: none"> Created strategic planning template for all Medicaid MCOs to document APM goals and establish a timeline. 	<ul style="list-style-type: none"> Medicaid met one-on-one with Medicaid plans and reviewed and adjusted goals. 	<ul style="list-style-type: none"> Plans understand the expectations for progress toward APM goals and are held accountable under the timeline.
NY	<ul style="list-style-type: none"> DFS, the regulatory agency that reviews commercial insurance rates under prior approval, attended regional collaborative meetings to engage commercial payers. 	<ul style="list-style-type: none"> DFS agreed to work with the Office of Health Insurance Programs under a memorandum of understanding to align VBP standards between Medicaid and the commercial sector. 	<ul style="list-style-type: none"> Could move payers to action because of parallel engagement across business lines. Simplifies VBP contracting for payers with Medicaid and commercial business (through Medicaid Delivery System Reform Incentive Payment).
TN	<ul style="list-style-type: none"> The Employee Benefits Administration removed downside risk for providers and made provider participation in the EOC payment model offered by state employee health plans voluntary. 	<ul style="list-style-type: none"> The Employee Benefits Administration worked with Medicaid and Tennessee Medical and Hospital Associations to modify the model. 	<ul style="list-style-type: none"> EOCs are part of state employee provider network contracts but do not include downside risk, as in TennCare (Medicaid) contracts.
WA	<ul style="list-style-type: none"> The third-party administrator for the public employees' Uniform Medical Plan will be required to contract with ACNs in its commercial product. Passed legislation directing the HCA to begin administering health care benefits for all school employees as of January 2020. 	<ul style="list-style-type: none"> Established the School Employees Benefit Board to purchase health care benefits with state employees. 	<ul style="list-style-type: none"> Expands accountable care contracting in commercial sector. Expands employee benefit enrollment pool for VBP products.

ACN = Accountable Care Network; APM = alternative payment model; DE = Delaware; DFS = Department of Financial Services; EOC = episode of care; HCA = Health Care Authority; MCO = managed care organization; MI = Michigan; NY = New York; SIM = State Innovation Model; TN = Tennessee; VBP = value-based payment; WA = Washington.

also convening meetings with Medicaid managed care plans and holding one-on-one meetings to review each plan's payments and performance measures. In New York, the Department of Financial Services (DFS), which reviews commercial insurance rates, began attending regional collaborative meetings. Separate from the SIM Initiative, DFS agreed to work with Medicaid under an interagency memorandum of understanding to align VBP guidelines. Commercial payers viewed both actions as important for driving regional collaboration around VBP.

Some states used procurement and regulatory strategies. Rhode Island required contracted MCOs to participate in the PCMH program and to contract with Accountable Entities. Although Rhode Island was the only SIM Round 2 state to mandate commercial plan participation in APMs, the state demonstrated flexibility in response to payers' assessment of attainable targets and agreed to maintain the APM target for calendar year 2019 at the 2018 threshold of 50 percent.¹³ Delaware and Washington are using procurement means to expand VBP contracting in state employee contracts. In Washington, the public employee ACNs will be leveraged to impact VBP contracting in the commercial sector, effective in 2019. Washington also passed legislation directing the HCA to administer health benefits for all school employees, which will increase the HCA's negotiating leverage in health plan procurement and expand the employee pool for VBP products. Ohio had already added a requirement to state employee health plan contracts for alignment with the SIM Initiative but without further specificity as of March 2018.

Providers continued to voice concerns about payment models, as in previous years.

Concerns about payment were raised frequently in interviews with providers in Ohio, Michigan, Colorado, and Delaware. Notably, these concerns were not limited to Medicaid. SIM officials or payers sometimes echoed these concerns. States did not indicate plans to raise PMPM payments or payment incentives in core APMs. States and health plans still search for the most effective way to use FFS billing in conjunction with a PMPM or VBP component for provider payments. However, the designs of the VBP arrangements did not appear to have typically involved a re-assessment of the objectives and purpose of FFS billing, and how best to achieve balance between VBP payments and FFS reimbursement was not explored.

"I would say it [Medicaid PMPM] is marginally inadequate to focus on the SIM population, it is wholly inadequate to focus on the whole population with the funding they are providing us."

—Michigan provider association

¹³ Office of the Health Insurance Commissioner (OHIC), State of Rhode Island. (2018, January 24). *Rhode Island 2018 Alternative Payment Methodology Plan*. Retrieved from <http://www.ohic.ri.gov/documents/2018-Alternative-Payment-Methodology-Plan-FINAL-2018-1-24-FINAL.pdf>

In some states, providers described payments as inadequate to cover the cost of staffing new care teams. Providers in other states described the incentive payments as too low to change practice behavior. In Ohio, for example, stakeholders, referring to Medicaid EOC payments, described payments as being too low to be an incentive, not too low for services reimbursement.

In Michigan, provider organizations perceived the PMPM as too low to cover new activities at primary care practices. Another Michigan provider association's concern was not the PMPM in Medicaid but the uneven payer support for care management and screening. The same issue

was raised by providers in Delaware, where the major concern was that most payers were not paying care coordination fees at all, meaning that many patients have no PMPM to cover care coordination services. Without support from all payers, providers faced the ethical dilemma of

"We have essentially an add on, inadequate PMPM for care management and social determinant screening, and a bit of a quality incentive that is less than we get through our commercial payers, and that's stuck on the outside of the existing FFS model. So, I don't think we have seen transformation, and I don't see the momentum to get us there."

—Michigan provider organization

treating patients differently based on insurance source or absorbing the cost of treating patients without regard to insurer. Delaware is beginning to address this problem with a new Medicaid contractual requirement to pay PMPMs. Also in Delaware, FFS billing reimbursement was a cross-cutting theme for providers integrating behavioral and physical health. In the spring of 2018, the state's contractors were beginning to work with Medicaid on using the collaborative care codes to support BH integration.

"The three episodes for GI [gastrointestinal] are colonoscopy, EGD [esophagogastroduodenoscopy], and GI [gastrointestinal] bleeding. ... We are not paying much attention to it. There isn't a whole lot of money tied to it. ... For our work, what we get paid by Medicaid is so low and our collection percentage is so low. The amount of administrative burden involved in trying to collect money, I'm not sure there is a benefit for spending the administrative time. It is abysmal."

—Ohio specialty provider

Providers in the several states voiced concern about the cost of implementing and maintaining behavioral health integration. Many providers appreciated the SIM supports their practices had received, but the ability to sustain behavioral health integration transformation in the future remained a major concern for some, depending on their state's approach to behavioral health integration. Notably, interviews with Medicaid providers in Rhode Island and Tennessee participating in the Medicaid Section 2703 Health Home model did not uncover issues about sustainability or funding adequacy for behavioral health integration activities. Both states used the Medicaid Health Home state plan option as the vehicle to integrate care for individuals with serious mental illness and to sustain those integrated care models beyond the SIM timeframe. The Health Home state plan option includes a high federal matching rate for coordinated care payments (for the first eight quarters), although the option also requires states to target populations defined by federal statute.

Colorado, Connecticut, and Delaware all joined Rhode Island and Tennessee in implementing or encouraging VBP approaches that incentivize integrated, whole-person approaches to care. In Rhode Island and Tennessee, shared savings were linked to a quality strategy emphasizing two areas: initiation/engagement in alcohol/drug treatment and screening for clinical depression and follow-up planning. In Connecticut and Delaware the quality strategy focused only on the latter area of depression. In Colorado, the SIM Initiative did not weigh in on the approach to VBP incentives for practices.

With the exception of providers in Rhode Island and Tennessee, providers operating under VBP contracts with shared savings components expressed concern about three issues. The first concern was with the sufficiency of incentives to fundamentally transform delivery, sustain these changes, and generate an ROI. The ROI was described as necessary for providers to receive benefits through shared savings models. Providers also were concerned about being penalized for not meeting quality goals when they attribute part of the quality gap to patient noncompliance or disinterest in changing their own behavior. Finally, providers questioned how plans could fairly apportion credit between behavioral health and primary (or other acute) care providers, recognizing that no one has established methods for proving the relative value of behavioral health and primary care providers (PCPs) in driving patient outcomes or total cost of care.

2.2 What Progress Have State Innovation Model Round 2 States Made Toward Moving a Preponderance of Care (80 Percent) into Value-Based Payment?

KEY FINDINGS



- SIM officials focused on reaching 80 percent preponderance of care for SIM-targeted populations but rarely for the entire state population
- Some stakeholders believed that the SIM Initiative was laying the groundwork for future VBP health care in their state.
- Regulation and state purchasing power were seen as promising levers to ensure progress.
- Alignment and collaboration among payers and programs were seen as increasing.

2.2.1 Attainment of preponderance of care

SIM officials focused on reaching 80 percent preponderance of care for SIM-targeted populations but rarely for the entire state population—which, it was widely agreed, would require the state and its payers to align with VBP and APM goals.

Stakeholders in most states were hesitant to say they would reach the 80 percent preponderance of care goal by the end of the SIM test period and instead spoke of the SIM work as providing foundation for a shift in health care in their state. Colorado and Delaware stakeholders noted that

changing to a new way of delivering health care was difficult but that the SIM Initiative was creating the infrastructure to move the state in that direction, which would continue after the end of the test period.

At least some stakeholders in six states (Colorado, New York, Ohio, Rhode Island, Tennessee, and Washington) described the 80 percent preponderance of care goal as attainable for specific payer types, populations, or provider types, although there was no consensus in any state—and in at least one of these states, most interviewees were skeptical that preponderance of care goals could be met. Connecticut and Iowa experienced delays in implementing key initiatives, leaving state officials fairly certain they would not reach their preponderance of care goals, even within the SIM Initiative. Rhode Island stakeholders were more confident than those in other states that the 80 percent goal could be reached for populations across Medicaid and commercial payers, largely because of the regulatory standards they set for these payers. Washington was confident in its ability to reach public employee plans and Medicaid but said the spread of VBP by commercial plans had been slow. It should be noted that, even where states received status reports from commercial payers, the information was insufficient to confidently predict the speed and trajectory of VBP contracting in the commercial and employer-sponsored insurance sectors.

“I think the beauty of the SIM and all of the other things that are happening right now is the belief that we are moving to a VBP world.”
—Iowa state official

Payers or SIM officials across eight states (Colorado, Connecticut, Idaho, Michigan, New York, Ohio, Rhode Island, and Tennessee) described progress in VBP contracting running parallel to SIM models that will support objectives of SIM payment reforms. For example, Colorado, independently of the SIM Initiative, is launching Phase 2 of the Accountable Care Collaborative, which will integrate into one entity at the regional level the financial accountability in Medicaid for physical and behavioral health. As one state official shared, “I think [Phase 2 of the Accountable Care Collaborative] nicely aligns with what SIM is trying to do. So there will be one regional entity that is over both physical and behavioral health for our members.”

2.2.2 Regulation and state purchasing levers

Regulation and state purchasing power were seen as promising levers to ensure progress. Rhode Island stakeholders credited their confidence that they would reach their stated 80 percent goal by the end of the SIM test period to OHIC’s regulatory role and the affordability standards the state set for all payers. One Rhode Island state official, when asked about major factors involved in reaching the goal, stated, “It’s in OHIC’s regulations. It’s all aimed at that goal so [that is] what we’re trying to do to get us here.” It should be re-emphasized, however, that OHIC chose not to raise its 2019 VBP target for payers above its 2018 target of 50 percent because of payer pushback that a higher target was not attainable. Four other states (Delaware,

Michigan, New York, and Tennessee) previously relying on voluntary engagement with payers used purchasing levers or contractual requirements. Some of these states are using this lever for the first time, as already described, to move Medicaid, public employee plans, and commercial plans toward VBP.

Stakeholders in several states (Delaware, Iowa, Idaho, and New York) expressed frustration at the perceived reluctance of their states to leverage their regulatory authority and role as a purchaser, seeing this as a missed opportunity to ensure progress. For example, one provider stated, “If the state as a purchaser went into these groups, you get to really high numbers. This gets into the state using its levers to get there.” Another stakeholder pointed out that because of the large number of state employees in Delaware, a large share of the population’s health care was under state control. A provider in Iowa noted that the state “could actually be firmer on its directives to the MCOs.” An Idaho state official felt the state started off behind other states:

“Not enough time, and frankly from our starting point, we were not at a level that was in line with the rest of the nation, for even monitoring APM and payments. I mean this was starting from the ground and building up. So, we based on Award Year 1, or Award Year 2, we just reported on our Award Year 3, metrics, as far as percentage of payments and lives and all that good stuff. And then the collection of Award Year 4 data or data reporting for Award Year 3 is just beginning.”

2.2.3 Preponderance of care metrics

State metrics reflected movement toward a preponderance of care for some populations, although most states were not yet reporting statewide participation in all VBP or APMs. *Tables 2-3 and 2-4* show the populations reached by VBP and APMs reported by states as of March 31, 2018. These metrics are submitted as part of each state’s quarterly report and are intended to measure progress toward preponderance of care in the population of interest. All states, with the exception of New York,¹⁴ reported participation in VBP/APMs by Medicaid, statewide, or by commercial payers, although few submitted metrics for all three categories.¹⁵

¹⁴ New York reported participation in SIM care delivery models, however there was not yet a payment component therefore those data have not been included.

¹⁵ Additional metrics showing the payer expenditures by LAN category and progress among provider and provider organizations can be found in each state appendix.

Table 2-3 reflects the participation in SIM models among the statewide population (i.e., all residents regardless of insurance status or payer type) for states that reported these metrics. Reported participation in any SIM model, included for four states, indicates the highest reports in Idaho (24.6 percent) and Tennessee (23.2 percent). Three states, Idaho, Rhode Island and Delaware, reported statewide participation in VBP or APMs (including, but not limited to, SIM models), which reached almost 22, 23 and over 27 percent of their state populations, respectively. Rhode Island's total currently only includes the commercially insured population and indicates that more than one-third of Rhode Island's commercial population attributed to a Rhode Island ACO or PCMH. Rhode Island's focus on commercial payers through OHIC affordability standards and their ability to build on an existing PCMH program shows in their progress among commercial payers. These numbers represent an increase in the population reached for several states (Delaware, Tennessee, and Washington); other states (Colorado, Connecticut, Idaho, Rhode Island, and Iowa) submitted metrics for the first time. Michigan, New York, and Ohio had not yet submitted statewide metrics by the end of the AR3 analysis period.

Table 2-4 presents SIM model participation among the Medicaid population. Reported participation in any SIM model in Medicaid was highest among the Tennessee Medicaid population (because all Medicaid beneficiaries were eligible for EOCs). States ranged from 0 to 50.4 percent Medicaid participation in their respective SIM models. Ohio reported the highest percentage of the Medicaid population reached by their EOC model and 34.8 percent reached by their PCMH model. For Ohio, this value was an increase over the previous year (0 in PCMH and only 11 percent reached by EOCs). Connecticut saw a drop in its Medicaid percentage reached because of attrition resulting from the program's strict eligibility requirements (see **Appendix B**). Other states increased both their reporting and their model participation during the AR3 analysis period.

Table 2-5 shows SIM model participation among the commercial population. Only Rhode Island, Connecticut, and Washington submitted information for their commercial populations. Tennessee also provided some information from a separate source. Rhode Island also included the total number of commercially insured that are in some form of VBP/APM, including but not limited to, SIM and that metric is reflected in **Table 2-3**.

Table 2-3. Statewide populations reached by a value-based payment or alternative payment model in Round 2 Model Test states, as of the most recent reporting quarter

State	SIM models						SIM Initiative-wide (total)	Landscape Statewide (total)
	PCMHs	Health homes for medically complex patients	ACOs	BH integrated care models	EOC payment models	Other		
Colorado				325,132 ¹ (6.1%)			325,132 ¹ (6.1%)	-
				4,541 ² (.01%)			4,541 ² (.01%)	
Connecticut			-				-	-
Delaware	-		-				-	256,232 (27.4%)
Idaho	402,645 (24.6%)					-	402,645 (24.6%)	-
Iowa			-				-	686,865 (22.1%)
Michigan	-						-	-
New York	-						-	-
Ohio	-				-		-	-
Rhode Island				-		-	-	243,385 (23.1%)
Tennessee	242,031 (3.7%)	75,374 (1.2%)			-	-	1,542,563 ³ (23.2%)	-
Washington			56,766 (0.8%)	176,400 (2.5%)		308,611 ⁴ (4.4%)	- ⁶	-
						2,381 ⁵ (0.03%)		

Source: Most recently available SIM Quarterly Progress Reports to CMMI that includes this report period: Award Year 2, Report 5 (Connecticut); Award Year 2, Report 6 (Michigan); Award Year 3, Report 2 (Colorado); Award Year 3, Report 3 (Iowa, Rhode Island); Award Year 3, Report 4 (Delaware, Idaho, New York, Ohio, Tennessee, Washington).

ACO = accountable care organization; AY = Award Year; BH = behavioral health; CMHC = community mental health center; CMMI = Center for Medicare and Medicaid Innovation; EOC = episode of care; FQHC = Federally Qualified Health Center; LTSS = long-term services and supports; PCMH = patient-centered medical home; PMPM = per member per month; RHC = rural health clinic; SIM = State Innovation Model.

— = relevant data were not provided in data source; shaded cells = the field is not applicable for that state.

¹ Population impacted by SIM primary care practice transformation.

² Population impacted by SIM CMHC practice transformation.

³ All 1,542,563 Medicaid beneficiaries were eligible for an episode if they had a diagnosis or event that triggered an episode. Consequently, the state reports that 100% of the Medicaid population is reached by a VBP model.

⁴ Participation in the FQHC and RHC PMPM payment model.

⁵ Participation in the Greater Washington Multi-Payer Model.

⁶ A SIM Initiative-wide total was submitted for AY2 but is not yet available for AY3.

Note: Denominators for all states are provided by United State Census American Community Survey 5-Year Estimates (<https://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml>; accessed on May 31, 2018). Colorado data for the primary care practice population reflects metrics submitted for Award Year 2, Annual Report, and data regarding CMHC population reflects metrics submitted for Award Year 3, Report 2. Connecticut data reflect metrics submitted for Award Year 2, Annual Report. Delaware data reflect metrics submitted for Award Year 3, Annual Report. Idaho data reflect metrics submitted for Award Year 3, Report 4. "Other" is for the virtual PCMH model, which is a subset of the reported primary care PCMHs, and a designation only PCMHs participating in the SIM Initiative can attain. Iowa data reflect metrics submitted for Award Year 2, Annual Report; Medicare is not included in the numerator. Michigan data reflect metrics submitted for Award Year 2, Report 6. New York data reflect metrics submitted for Award Year 3, Annual Report. Ohio data reflect metrics submitted for third quarter 2017. Rhode Island data reflect metrics submitted for Award Year 2, Annual Report. The "other" category is pediatric PCMH (PCMH-Kids). Tennessee data reflect metrics submitted for Award Year 3, Annual Report. The "other" category is LTSS. Washington data reflect metrics submitted for Award Year 3, Report 4.

Table 2-4. Medicaid populations reached by a value-based payment or alternative payment model in Round 2 Model Test states, as of the most recent reporting quarter

State	SIM models					SIM Initiative-wide (total)
	PCMHs	Health homes for medically complex patients	ACOs	BH integrated care models	EOC payment models	
Colorado				-		-
Connecticut			109,356 (16.7%)			109,356 (16.7%)
Delaware	-		-			-
Idaho	-					-
Iowa			0 0%			0 0%
Michigan	333,501 ¹ (16.3%)					333,501 (16.3%)
New York						
Ohio	836,026 (34.8%)				1,096,792 (50.4%)	-. ²
Rhode Island				-		-
Tennessee	242,031 (20.8%)	75,374 (6.5%)			-	1,542,563 ³ (100%)
Washington				176,400 (13.8%)		308,611 ⁴ (21.4%) - ⁵

Source: Most recently available SIM Quarterly Progress Reports to CMMI that includes this report period: Award Year 2, Report 5 (Connecticut); Award Year 2, Report 6 (Michigan); Award Year 3, Report 2 (Colorado); Award Year 3, Report 3 (Iowa, Rhode Island); Award Year 3, Report 4 (Delaware, Idaho, New York, Ohio, Tennessee, Washington).

ACO = accountable care organization; AY = Award Year; BH = behavioral health; CMMI = Center for Medicare and Medicaid Innovation; EOC = episode of care; FQHC = Federally Qualified Health Center; LTSS = long-term services and supports; PCMH = patient-centered medical home; PMPM = per member per month; RHC = rural health clinic; SIM = State Innovation Model.

— = relevant data were not provided in data source; shaded cells = the field is not applicable for that state.

¹ Total number of Medicaid beneficiaries meeting inclusion criteria to receive care through a SIM-funded PCMH.

² A total unduplicated count of Medicaid beneficiaries impacted by one or more model was not available.

³ The denominator provided by the US Census American Community Survey estimates is larger than the one reported by the state, resulting in more than 100% coverage; we have reported this as 100%. All Medicaid beneficiaries were eligible for an episode if they had a diagnosis or event that triggered an episode.

⁴ Participation in the FQHC and RHC PMPM payment model.

⁵ A SIM Initiative-wide total was submitted for AY2 but is not yet available for AY3.

Notes: Denominators for all states are provided by United State Census American Community Survey 5-Year Estimates (<https://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml>; accessed on May 31, 2018). Colorado data reflect metrics submitted for Award Year 3, Report 2. Connecticut data reflect metrics submitted for Award Year 2, Annual Report. Delaware data reflect metrics submitted for Award Year 3, Annual Report. Idaho data reflect metrics submitted for Award Year 3, Report 4. Iowa data reflect metrics submitted for Award Year 2, Annual Report. Michigan data reflect metrics submitted for Award Year 2, Report 6. New York data reflect metrics submitted for Award Year 3, Annual Report. Ohio PCMH data reflect metrics submitted for third quarter 2017, and Ohio EOC data reflect metrics submitted for second quarter 2017. Rhode Island data reflect metrics submitted for Award Year 2, Annual Report; the “other” category refers to pediatric PCMHs (PCHM-Kids). Tennessee data reflect metrics submitted for Award Year 3, Annual Report, except for EOC data, which reflect Award Year 2, Annual Report; the “other” category is LTSS. Washington data reflect metrics submitted for Award Year 3, Report 4.

Table 2-5. Commercial populations reached by a value-based payment or alternative payment model in Round 2 Model Test states, as of most recent reporting quarter

State	SIM models					SIM Initiative-wide (total)
	PCMHs	Health homes for medically complex patients	ACOs	BH integrated care models	EOC payment models	
Colorado				-		-
Connecticut						221,468 (8.7%)
Delaware	-		-			-
Idaho	-					-
Iowa			-			-
Michigan						-
New York	-					-
Ohio	-				-	-
Rhode Island				-		35,991 (4.9%) ¹
Tennessee					-	-
Washington			56,766 ² (1.2%)			56,766 ² (1.2%)

Source: Most recently available SIM Quarterly Progress Reports to CMMI that includes this report period: Award Year 2, Report 5 (Connecticut); Award Year 2, Report 6 (Michigan); Award Year 3, Report 2 (Colorado); Award Year 3, Report 3 (Iowa, Rhode Island); Award Year 3, Report 4 (Delaware, Idaho, New York, Ohio, Tennessee, Washington).

ACO = accountable care organization; BH = behavioral health; CMMI = Center for Medicare and Medicaid Innovation; EOC = episode of care; PCMH = patient-centered medical home; SIM = State Innovation Model.

— = relevant data were not provided in data source; shaded cells = the field is not applicable for that state.

¹ A total unduplicated count of commercial beneficiaries impacted by one or more model was not available.

² The numerator is the total Public Employee Benefit Accountable Care Plan (ACP) covered lives (including PEB members who actively selected one of the ACP options and those attributed but still in PPO plan). For each quarter, the middle month is used Q1=Feb, Q2=May Q3=Aug Q4=Nov. Taken from Milliman COS reports.

Notes: Denominators for all states are provided by United State Census American Community Survey 5-Year Estimates (<https://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml>); accessed on May 31, 2018). Colorado data reflect metrics submitted for Award Year 3, Report 2. Connecticut data reflect metrics submitted for Award Year 2, Annual Report. “Other” includes commercially covered lives with a value-based insurance design insurance plan; survey is outstanding with 2 payers. Delaware data reflect metrics submitted for Award Year 3, Annual Report. Idaho data reflect metrics submitted for Award Year 3, Report 4. Iowa data reflect metrics submitted for Award Year 2, Annual Report. Michigan data reflect metrics submitted for Award Year 2, Report 6. New York data reflect metrics submitted for Award Year 3, Annual Report. Ohio data reflect metrics submitted for third quarter 2017. Rhode Island data reflect metrics submitted for Award Year 2, Annual Report. The “other” category refers to pediatric PCMHs (PCMH-Kids). The SIM Initiative-wide total reflects the unique count of insured members attributed to a PCMH or ACO. Tennessee data reflect metrics submitted for Award Year 3, Annual Report. Washington data reflect metrics submitted for Award Year 3, Report 4.

2.3 What Progress Have State Innovation Model Round 2 States Made Toward Delivery Transformation?

KEY FINDINGS



Progress

- Reported improvements in the identification and treatment of behavioral health needs suggested investments in behavioral health integration might be having their intended impacts.
- Stakeholders in Colorado, Connecticut, Delaware, Tennessee, Rhode Island, and Washington reported increased capacity to identify patients in need of behavioral health services and to better connect patients to needed services.
- Three states increased care coordination through an expansion of their ADT systems. Providers had mostly positive reactions to these systems, which emerged as an essential tool for care coordination in PCMH models.
- Peer-to-peer TA models emerged as a promising approach to sustaining learning and building capacity with limited resources.

Barriers

- Providers viewed care coordination as beneficial to their practices and their patients. However, resources were insufficient to meet the high demand for care coordination. Consequently, some practices by necessity prioritized care coordination for patients with the highest needs.
- Alignment of quality measures remained a key focus of practice transformation. However, some providers deemed the burden of reporting as still too high and the value of the data too low; these issues represent barriers to full PCMH engagement.
- Providers in Connecticut, Idaho, Michigan, and Rhode Island emphasized the critical role CHWs played in delivering coordinated care, but funding of CHW services remained a key barrier to sustaining these positions.
- The impact of strategies to address workforce shortages was not evident in the AR3 analysis period, but given the pervasiveness of workforce shortages, current strategies might not be sufficient to cover the needs, particularly for rural populations.

Prior to the SIM Initiative, states recognized that most providers were not ready to engage successfully in VBP arrangements and that many providers would not initiate transformation or succeed under VBP without payer and state supports and facilitation. SIM funds enabled states to use different types of supports to help providers achieve transformation objectives. Many states provided significant support to physician practices, FQHCs, and CMHCs to prepare practices to operate successfully under VBP contracting, such as TA, coaching, feedback reports, etc.). Primary questions for SIM leadership were (1) whether SIM investment and support led to transformed systems of care, (2) whether stakeholders would find value in maintaining these supports after SIM funding ends, and (3) how states intended to sustain those supports.

Evidence collected began to reveal areas where the greatest transformation occurred within primary care, where transformation was slow or appeared to have stalled, and factors contributing to these implementation outcomes. Investigating provider experiences could help other stakeholders understand the limitations of existing arrangements to accelerate system transformation and learn of the unintended consequences of different payment methods.

This section synthesizes cross-cutting qualitative evidence of delivery transformation from providers, consumers, state officials, and state partners. The RTI team reviewed stakeholder feedback on the strategies (or absence of strategies) enabling or hindering transformation for the following strategic investment areas: behavioral health integration, care coordination, health IT, data for improving health care quality, training and TA, and workforce development.

2.3.1 Behavioral health integration

Providers reported improvements in screening for behavioral health needs and connecting patients to care. While many providers noted that capacity in behavioral health integration preceded the SIM Initiative (often supported through state PCMH initiatives), provider comments overall indicated that SIM prioritization, upfront investments, and varied supports to practices had created momentum in behavioral health screening, coordination, and linkages to treatment.

Screening. Many PCPs interviewed had added practice protocols to administer behavioral health screening tools at every encounter for every patient (universal screening). Providers in Rhode Island commented that new pathways to provide patients with services had greatly improved screening rates although another provider noted that actual follow-up still proved challenging. Connecticut embedded behavioral health screening and follow-up as a core strategy in its Community and Clinical Integration Program requirements. Those entities, in turn, complemented the work of providers and systems participating in the state’s PCMH, Person Centered Medical Home Plus, and Advanced Medical Home initiatives. Providers reported using different kinds of staff to administer screening, including front desk staff and medical assistants who first encounter the patient. Universal screening has identified their population needs for mental health and substance abuse services far beyond what they anticipated, and PCPs reported their growing awareness of the importance to screen patients at every encounter.

“While we’ve had integrated mental health in our clinic, this project really allowed us to extend our reach in terms of screening adolescents for depression. And then, I think, brought a greater awareness to our team as well about the prevalence of some of these issues and the importance of screening every time at every encounter.”

—Colorado provider

Coordination and linkages. In Connecticut and Rhode Island, CHWs and community health teams (CHTs), respectively, assisted practices in coordinating behavioral health and other needs. Other practices described approaches considered less than ideal. In Colorado, several primary care practices involved in behavioral health integration described relying on licensed clinical social workers to perform care coordination tasks, and these tasks were often not billable to a payer. The time spent on care coordination took away from the social workers' time available for direct clinical care. These practices reported applying for a small grant funded by the Colorado Health Foundation¹⁶ to hire a care coordinator, but the practices did not receive the grant. As a result, these primary care practices had to rely on social workers and cover the cost of the social worker's care coordination time.

"I'm a licensed clinic social worker, and I spend probably 40 percent of my time finding diapers for a mom that we screened who's depressed, or transportation for a girl through school issues, and IEP [Individualized Education Plan] meetings. I'm like, there's so many things that are not clinical that I'm doing. And it's great I can do it, and my clinic is paying for that. I can't really get reimbursed for a lot of that..."

—Colorado provider

Treatment. Rhode Island funded a pediatric consultation program that enhanced the ability of PCPs to treat children's behavioral health issues without the need to refer to behavioral health specialists. The state also supported a pilot to assist providers in embedding behavioral health clinicians into primary care. In Colorado, the integration of behavioral health staff in primary care settings has enhanced capacity in primary care to address patients' physical health goals. As an example, licensed behavioral health staff at one practice followed up with patients who had not made progress on physical health goals, such as lowering A1C levels among patients with diabetes. Through engaging these patients, staff identified behavioral health needs that had previously been missed, and that were creating barriers to addressing patients' physical health goals.

Integrating physical health care within community mental health settings proved valuable. Colorado's four CMHCs participating in the bidirectional health home pilot used SIM resources to improve delivery of integrated primary and behavioral health care for select populations. Tennessee required partnerships across behavioral health providers and PCPs as a condition of participation in its Health Link and PCMH programs. Washington continued to implement integrated physical and behavioral health services within its Medicaid managed care system, and the state's behavioral health providers in the early adopter region reported using, for the first time, the MCO care coordination resources to address improved access to health care for their patients' physical health conditions.

¹⁶ In support of Colorado's SIM Initiative, the Colorado Health Foundation agreed to support SIM-participating primary care practices through a competitive small grant program that would provide practices with funds to support behavioral health integration, including hiring behavioral health providers or care coordinators.

States that facilitated access to data (in both primary care and behavioral health settings) saw rapid changes in how providers delivered care. As in other areas of system delivery transformation, data emerged as a key factor in the promotion of behavioral health integration. Several states developed data tools or invested in training and practice supports so providers could use data more effectively. In Rhode Island, community mental health providers found that the ADT information obtained from a SIM-funded data dashboard had a significant impact, enhancing providers' ability to locate and reach out to patients not actively engaged in care and to have a more complete picture of physical health needs: "With access to data, providers report creating multidisciplinary teams for high-risk clients, developing individualized care plans, and using hospital and ER data to define high-risk cohorts." A behavioral health provider in Tennessee described access to data from the CCT to be a "game changer." Payers also perceive the CCT as an asset and assisted in working out glitches to help providers make better use of the data.

"It's [data dashboard] amazing. Some people have been in the ED [emergency department] 25 times, but we thought it was only 4."
—Rhode Island provider

Delaware leveraged mandatory post-adjudication reporting of claims from state-based plans (Medicaid and state employee health plans) to bolster purchaser participation in its Health Care Claims Database. However, providers in Washington, Colorado, and Delaware noted that federal regulation regarding the confidentiality of substance use information (42 CFR Part 2) prevented the state from fully sharing information to support integrated care.

Behavioral health workforce shortages might limit the spread of behavioral health integration. Stakeholders across states noted the general scarcity of trained behavioral health providers, especially in rural areas. SIM workforce efforts focused largely on training and changing workflow to improve existing workforce efficiency. Behavioral health providers noted the need for new types of training and competencies to work in integrated primary care settings. Colorado, for example, released e-learning modules to address behavioral health competencies in primary care. In community behavioral health clinics, providers said they needed more training to effectively coordinate and manage physical health care needs. Several states also supported telemedicine, psychological consultation services, and care teams to stretch available clinical expertise.

2.3.2 Care coordination

As the result of SIM strategies, providers report expanding the number of patients served by care coordinators for a broader scope of referral needs than they could offer prior to their involvement in the SIM Initiative.

States have supported care coordinator positions or teams directly through their SIM grants and have indirectly supported care coordination through such resources as

TA, facilitators, and billing and coding for care coordinators or coordination services (Colorado Connecticut, Delaware, Iowa, Michigan, Rhode Island, and Tennessee). One provider described the importance of these funds for preparing them to succeed under new payment models. Another described the investment as transformative to their practice.

“We have a large Medicaid population in our clinic. So it’s also helping us get ready for some new kind of alternative payment models that are coming out in the next couple years, so it’s really allowing us to get ready for those.”

—Colorado provider

Through these SIM strategies, practices were able to hire or contract for staff positions that focused on coordinating care, including CHWs, health care navigators, and allied health workers—and embedded them into care teams. The activities of these staff members included managing patients with poorly controlled chronic conditions, tracking referrals, contacting ER patients for follow-up at the practice, adding behavioral health care plans and developing social care plans (including housing, transportation, social support, and food security). Others described training medical assistants to interact with patients and conduct screenings. In Iowa, care coordinators have been hired by C3s to perform the same kinds of activities as in other states yet may be located in the community, embedded in health care settings, and conduct home visits.

“We’re starting to screen for social needs and actually learning a lot about the community. ... we’ve come to find out that there’s a lot more need for that kind of screening and providing resources”

—Colorado provider

Resources for care coordination have helped providers meet patient’s social determinant needs.

Providers were enthusiastic about the impact the care coordinator workforce is having on patients’ overall well-being and in reducing excessive use of ERs and hospitals. Moreover, practices are addressing the nonmedical needs of their patients that impact their well-being by first screening patients for SDoH, such as housing instability and poverty, and then bringing in the care coordinator to find appropriate social services or help them find other resources, such as diapers.

In some states, providers described difficulty establishing a sustainable model for care coordination in their practices that also met the needs of their patients Providers in different PCMH initiatives shared one of two problems: demand for care coordination is higher than was anticipated when PMPM rates were set, and some care coordination tasks or individuals performing coordination tasks are not reimbursable. Providers facing this dilemma developed different strategies, including clinical protocols to manage care for specific groups of high-needs

patients. For example, patients with high hemoglobin A1c values received health coaching for diabetic care in Iowa. Other strategies for prioritizing patient populations included limiting care coordination to patients based on insurance source and serving patients of all payers, regardless of which payers paid for coordination services (i.e., to avoid cost-shifting). Notably, the rare providers able to secure payment to cover care coordination *for all their payer populations*

"... now we're doing embedded care management for all our payer populations. That has been very helpful for practices. They were struggling to figure out who qualified for care management and it was complicated. But now we're pretty much across the board."

—Michigan Independent Practice Association official

appeared to have the fewest care coordination challenges. It remains unclear whether the issues reported by specific practices are related to payment strategies for care coordination under state-preferred PCMH models or PCMH contracts with commercial payers who may not be aligned with SIM Initiatives. This is an area where further inquiry is needed.

2.3.3 Health information technology

SIM-funded enhancements to health IT were intended to give providers a more complete view of their patients' health care use patterns and spending, improve patients' health care coordination, and take on and manage financial risk. Many states viewed their health IT enhancements as a driver of provider participation in health care transformation, by supplying the information needed for VBP and APM adoption. HIE was central to the SIM Initiative in many of the states and was defined as the transmission of health care-related data among facilities, health information organizations, government agencies, and patients.¹⁷ SIM-funded HIE enabled clinicians, nurses, pharmacists, other health care providers, and patients to appropriately access and securely share electronically a patient's vital medical information.¹⁸

Common HIE supports that states developed included expanding HIE to more providers, improving HIE data functionality for care coordination, and using ADT notifications. Other SIM-funded health IT enhancements included the following: (1) direct support for APCDs and APCD enhancements to identify gaps in population health management and create quality metric benchmarks (Delaware, New York, and Rhode Island), (2) support providers' effective use of electronic health record (EHR) systems for behavioral health integration (Colorado and Delaware), (3) helping providers develop the processes and infrastructure to collect and report eCQMs (Colorado, Delaware, Michigan, and Iowa), and (4) statewide health provider directories (Colorado, Rhode Island, and Michigan). SIM-funded health IT enhancements have been a small

¹⁷ U.S. Department of Health & Human Services. (2014). *Health information exchange (HIE): What is HIE?* Retrieved January 30, 2018, from <https://www.healthit.gov/providers-professionals/health-information-exchange/what-hie>

¹⁸ Ibid.

component of much broader state activities outside of SIM to expand EHR data available to providers through HIEs.

Providers and consumers viewed ADT systems as an important asset for coordinating care.

ADT alerts were among the strategies for advancing care coordination through the SIM Initiative in Iowa, Michigan, Rhode Island, and Tennessee that providers perceived as having high value. ADT notification systems (also called ADT alerts) are an HIE technology that sends real-time alerts to health care providers to indicate when their patients receive services in an ER or are

“... the dashboards, are [the] best thing to happen in the state-funded part [of the SIM Initiative]. ... We use it for our entire population. Every 45 minutes, we have an updated file. It comes into a portal here, and we have it automated, in some circumstances information goes to the nurse, some to the medical assistant, some to a pharmacist, some to a behavioral health provider. And we make those phone calls within 48 hours to the patient”

—Rhode Island provider

admitted, discharged, or transferred from a hospital.¹⁹ In the AR3 analysis period, each of these four states implemented or expanded its ADT system to new groups of providers, allowing more patients to benefit from physician follow-up. In Rhode Island, data dashboards became operational in seven CMHCs to better coordinate services. The states’ roles were to establish or support existing common platforms for exchanging ADT information. SIM stakeholders generally increasingly recognized ADT alerts as a necessary component of coordinating health care for the benefit of patients.^{20,21} Consumers in these and other states with ADT systems independent of the SIM Initiative reported being contacted by their doctors when they were hospitalized or used the ER. They were pleased and, in some cases, impressed with how the system enabled their doctors to contact them and follow-up with needed care after post-discharge from the hospital.

¹⁹ U.S. Department of Health & Human Services, Office of the National Coordinator for Health Information Technology. (2013, May). *Improving hospital transitions and care coordination using automated admission, discharge and transfer alerts: A learning guide*. Retrieved from <https://www.healthit.gov/sites/default/files/onc-beacon-lg1-adt-alerts-for-toc-and-care-coord.pdf>

²⁰ State Health Information Exchange Program, Office of the National Coordinator for Health Information Technology. (2012, December). *State HIE bright spots synthesis. Care coordination part 1: Getting to impact: Harnessing health information technology to support improved care coordination*. Retrieved from https://www.healthit.gov/sites/default/files/bright-spots-synthesis_care-coordination-part-i_final_012813.pdf

²¹ Galvez, E. (2013, March 26). *HIE bright spots: How ADT messages support care coordination—Part II*. Retrieved from <https://www.healthit.gov/buzz-blog/state-hie/hie-bright-spots-adt-messages-support-care-coordination-part-ii>

Providers embraced health IT enhancements that improved the timeliness of meaningful information at the point of care.

Providers and payers embraced health IT initiatives in at least three states (Michigan, Rhode Island, and Tennessee) as effective because providers found either (1) a clear use for the data in the coordination

of patient care or (2) that data helped providers achieve contractual objectives (such as reducing the cost of care and improving quality). These HIEs included the Michigan Health Information Network, Rhode Island’s CMHC dashboards, and Tennessee’s CCT. A fourth state, Iowa, was able to expand the number of hospitals uploading data to its ADT system, SWAN within the Iowa Health Information Network; however, providers have not embraced its use as readily.

“... the technology is delivering the information, but how you use that technology on the other end ... is really hard work. [The SIM Initiative] was our chance to build the experience, even though sometimes it’s a little messy.”

—Michigan provider

Providers consistently identified two health IT features as essential for meeting providers’ needs: (1) information available at the point of care and (2) point-of-care information that was timely and meaningful enough to support informed decision making. The Michigan

“We’ve seen a lot of interest and improvement in terms of providers reviewing and analyzing data and making decisions about their practice on things they want to work through and transform...the CCT coming online is really important.”

—Tennessee provider

Health Information Network promoted standardization among regional HIEs, thereby reducing the number of systems providers needed to use and facilitating the use of medical information by physicians at the points of care. The use of Tennessee’s CCT spread widely during the AR3 analysis period. TennCare regulations for both PCMH and Health Link providers created the expectation that these providers would use CCT regularly as a

condition of program participation. Although CCT was mandated, providers welcomed the tool as important for provider decision making. In Rhode Island, CMHCs received alerts from hospitals for behavioral health consumers through the CMHC dashboards, with stakeholders reporting that the dashboard alerts reduced utilization for patients with complex behavioral health conditions.

Five states continued to support greater interoperability of data systems for uses beyond ADT alerts through, or outside, the SIM Initiative, but significant hurdles to broader use remained in some states. In five states (Iowa, Idaho, Michigan, Tennessee, and Washington), SIM funds facilitated greater data system interoperability and coordination among health care data owners. Tennessee, for example, used its Care Coordination Tool for sharing information about clinical encounters other than those captured in ADT alerts. Both Tennessee and Michigan advanced methods for attributing patients to their primary care practices through electronic assignment algorithms. SIM funding also helped states establish standards among providers to enable data exchange and use. In addition, SIM Initiatives experimented with

different requirements for data submission, use, and fee structures that reward hospitals and physician practices for participating in data exchange to improve patient care.

However, significant hurdles delayed or forestalled progress in three states (Idaho, Iowa and Michigan). The challenges in these states reported by stakeholders were challenges with how EHRs can share information bidirectionally, legal issues surrounding data privacy, and the financial disincentive from EHR vendors charging providers to enable connections. Idaho stakeholders said that this combination of factors might prevent some practices from being linked to the state's information exchange network within the SIM test period. In Michigan, providers were more optimistic about progress, reporting that alerts could potentially improve enough for practices to receive aggregated reports for entire patient panels, rather than multiple piecemeal alerts for each patient. In Iowa, providers noted that SWAN provides limited information through the Medicaid plans and ACOs relative to the information commercial plans make available to providers for their commercial patients. The state is responding by rolling out a new alert system that has greater capacity to deliver more clinical information to the points of care.

2.3.4 Data for improving health care quality and performance

As reported in AR1 and AR2, many SIM states engaged in quality measure alignment efforts to support expansion of VBP contracts, focused on establishing common measure sets and common definitions of those measures. More recently, states turned their focus to refining common measure sets, encouraging and supporting measure adoption by additional payer groups, ensuring data quality, and engaging in provider and public reporting activities. At the same time, however, existing workgroups either met with less frequency or had their functions rolled into other groups.

Commercial payers emphasized the importance of aligning quality measures to spread APM adoption. Virtually every commercial payer interviewed across states viewed the alignment of quality measures as the highest priority based on their direct experience with providers. From a New York payer: "Some of these groups have complained that certain payers are asking them for 20 or 30 measures and the way they report to one is different than what they have to report for another, so trying to get that number down was a step in the right direction." From an Ohio payer:

"On the whole we realize that asking providers to do very different things than what everyone else is asking them to do doesn't really achieve goals. We hear a lot of feedback from providers that if providers are measured on too many things they won't be successful, so we try to align in a way that makes sense to provide quality and the value we're looking for."

The burden to a provider of reporting obligated to one payer can undermine the efforts of other payers. As one New York payer explained, “Because one practice likely deals with many payers (given the small market share of any one insurer), the reporting burden of one insurer can interfere with ability of other insurers to gain a contract.”

Payers generally agreed that aligning quality measures within payer cohorts was important but differed in their views of the importance of aligning measures across payer cohorts. Some payers viewed cross-payer alignment as unnecessary. According to one Tennessee payer,

“you see practices really set themselves up to cater to specific populations, or they have density in certain population groups.... It’s kind of a rare exception where you see a physician’s practice have a perfect balance between Medicare, commercial, and Medicaid. This whole concept of needing to be perfectly aligned across payers because it makes it easier on providers, I don’t think that’s true.”

Other payers described large practices as frequently requiring customized contracts that align measures or measure specifications with another contract held by the practice. In large part, provider feedback and behavior have helped determine the degree of quality measure alignment needed across payer cohorts.

The burden of reporting and lack of actionable feedback continues to be a barrier for practice transformation; however, promising strategies to overcome these barriers emerged in a few states. Although Medicaid and commercial payers in some states were at the table to develop common measure sets and tackle implementation issues, the use of these common measures and measure specifications by health plans remained voluntary in all the states except for Rhode Island (where it is mandatory).

Providers in Colorado, Connecticut, and Delaware described the reporting requirements they faced as too burdensome, suggesting that officials had not done enough to date to address provider concerns. For some providers, it was the totality of effort required across contracts that was excessive, rather than a specific payer’s action. A few states worked directly with providers

to address their experience with quality reporting, but the lack of timely data or data received that were not reconciled with providers’ own data remained a barrier to their full engagement in the transformation process. In Ohio providers did not have complaints about reporting burden, namely because all measures for Ohio are based on claims data. However, there was criticism that the measures were not useful

“There are limitations to the data that the state uses. They only have claims data from the data warehouse. The scores they produce from their warehouse are lower than what we produce—we have data from EHR, registry, supplemental data, HIE, lab results, etc.”

—New York health plan

because the data were not timely, in contrast to what providers could access in their EHRs.

Quality measures based on data from medical claims (unlike ADT alerts which come from EHRs) are received months after services are received and do not allow providers to intervene with patients.

All but three states provided provider feedback reports as of March 2018. Providers and health plans highlighted four types of deficiencies in quality and gap reports: (1) the data were too old, (2) patients did not match those in the payer attribution reports, (3) recommended services were frequently outdated or not appropriate, and (4) the reports suggested no specific changes to improve a given quality metric. Gap reports also were described as duplicating the monitoring already underway or the reports received from payers. Providers also found that EHR data did not lend themselves to meaningful quality measurement. For instance, Colorado providers noted the absence of appropriate behavioral health data in EHRs for reporting quality measures.

Provider interviews suggested that some state efforts to address provider concerns regarding the burden of reporting were beneficial. In Colorado, providers reported that practice facilitators and clinical health IT advisors helped them better understand and use their data and manage data quality issues. Tennessee actively solicits provider feedback through its Technical Advisory Group (TAG), monthly provider stakeholder calls, email, in-person meetings, and Annual Episodes Design Feedback Session held in six cities across the state. Health plans in Colorado and Tennessee—both commercial and Medicaid—reported receiving provider complaints and described both one-on-one meetings with practices to find solutions and collective meetings to identify common issues and develop trainings. In contrast, in Ohio, specialists subject to episode payment incentives were caught off-guard by risk payments because they did not know how to interpret quarterly episode reports. Training to enhance their understanding of these reports is available but not mandatory. However, Ohio addressed provider concerns in other ways, by consolidating the separate episode reports providers received from each Medicaid managed care plan and FFS Medicaid into one document that combines data from all MCOs and FFS Medicaid and links to the Medicaid claims that generated the report. These consolidated episode reports were considered a “major improvement” over the prior experience of receiving episode reports from multiple plans.

PCMH-participating providers also described as a significant burden the cost of acquiring and maintaining EHR systems capable of both calculating quality measures for various payers and HIEs and supporting other uses (e.g., feedback reports, patient attribution). For example, Idaho’s SIM Initiative supported the cost of the HIE link for participating providers as long as the linkage was completed within the period of the SIM award. However, a lack of dedicated funding to connect providers to the HIE after the SIM test period was noted as a concern.

2.3.5 Training and technical assistance

Providers consistently described a range of changes they made to their practices as the result of SIM-enabled training and technical assistance (T&TA) support. Providers and state officials from Iowa, Michigan, and Rhode Island described the diverse achievements of T&TA in helping provider practice transformation efforts, included integrating behavioral health, improving delivery of care, reporting and using quality measures, and using telemedicine. In Michigan, stakeholders reported that Above and Below the Line Change training—designed to help CHIRs look at issues from a community perspective—had improved the capacity of those who completed the training to improve population health. Connecticut providers described their experience with TA support as mixed but found the University of Pennsylvania’s support on using and integrating the CHWs effectively and considering their ROI to be particularly helpful.

TA was specifically directed at impacting practice transformation objectives. Rhode Island state officials indicated that the SBIRT reintroduction to motivational interviewing incorporated into CHW-specific training was helpful. New York reported that individualized TA was helpful when tailored to the particular practice.

“This year the technical assistance has been wonderful from Iowa Healthcare Collaborative and Iowa Primary Care Association.... So, if we have questions on data or questions on how to facilitate from that public health—to that hospital and clinical—standpoint. So how do we talk to each other? How do we have that language? They have been very helpful with that.”

—Iowa stakeholder

In addition to these positive examples, providers and state officials pointed to some challenges that limited T&TA’s impact. Stakeholders in Idaho and Michigan noted that, as valuable as T&TA might be, practices were “really taxed with how much they can learn and how much they can do” and, as a result, could not always avail themselves of the learning opportunities offered. Colorado echoed this challenge. Rhode Island, in contrast, reported not having sufficient training capacity or trainers as the issue.

Stakeholders generally deemed T&TA tailored to specific needs as more useful than general information training. Stakeholders typically used words like “wonderful” and “critical” to describe the T&TA in their states. In contrast, interviewees from several states (Colorado, Michigan, New York, and Washington) tended to reserve those words for TA geared to the specific needs of their providers. For instance, Washington learned from its providers that general training on behavioral health integration was not as useful for behavioral health providers as assistance with

Which TA opportunities are most valuable:
“The ones that are more specific to the projects we’re working on have been more valuable. For example, using Medicaid data and ER utilization data has been valuable. But the kind of general tools for community assessment or for equity have been less valuable because we’ve already done that kind of work in the past.”

—Michigan provider

specific issues (e.g., billing). In response, Washington modified the TA offered to address the needs of the individual provider in ways similar to the New York experience noted above.

Providers in several states reported positive experiences with peer-to-peer approaches to practice support. Examples of successful peer-to-peer support (provided by the state or payers) included learning collaborative meetings, sharing best practices, small group and practice-led sessions, practice transformation office hours, and peer mentoring. An Idaho state official solicited topics on which practices either needed assistance or felt they could facilitate a Webinar to discuss successes and lessons learned; various practices then used this list to deliver well-attended and well-received Webinars. A Tennessee Medicaid MCO initiated small group sessions in which successful providers offered lessons to lower-performing providers around EOCs. Connecticut convened bimonthly meetings, in which all practices came together, that provided an “opportunity for them to talk to one another and come up with some solutions. Somebody may have found something that was working, and they can share that with everybody.” Connecticut practices also developed their own monthly forum for peer-building support because providers felt they needed to work out changes collaboratively. A Washington state official said the ACHs had initiated peer learning calls among themselves, focused on such topics as data, finance, and health IT.

Mentoring other clinics. “Most of the clinics are more than willing to be very helpful. And that’s something I’ve noticed in this state. Everybody fears the competition piece, but when it comes to sharing information with people who are trying to bring things in has been hugely beneficial. And they’re very willing to share.”
—Idaho provider

2.3.6 Workforce development

Stakeholders emphasized the role of CHW development practice transformation. Connecticut launched a Web site to serve as a platform for CHW training; one provider regarded the TA received as “the best technical assistance we’ve gotten” in moving their efforts forward in integrating CHWs into practices. Idaho provided CHW training curricula online to help extend training into rural areas. Rhode Island’s training for its CHTs included motivational interviewing techniques for the CHWs and approaches to educate clients about, and make referrals to, substance abuse treatment.

States also explored new approaches to funding and credentialing CHW services to sustain and expand the CHW workforce. Despite the general high regard for CHWs’ achievements, the long-term sustainability of this workforce remained an issue in several states because a means to cover the cost of CHW services had not yet been fully developed. According to Michigan CHIR providers, the state and Medicaid explored ways to reimburse CHWs, including FFS codes. Idaho providers participating in shared savings arrangements with commercial payers began to recognize that they could use the shared savings to cover the cost of CHWs and anticipated that Medicaid’s planned shared savings program would provide them

with additional funding for that purpose. Stakeholders in Idaho and Connecticut acknowledged the importance of assessing CHW ROI to help states and payers establish a policy for reimbursing CHWs. Using the SIM experience, Rhode Island wanted to demonstrate the value of CHWs for use in state discussions with payers about CHW reimbursement options.

Certification and licensing CHWs was another strategy considered important for achieving sustainability in Connecticut and Michigan. Connecticut, for example, enacted a new law creating a certification process for the CHW workforce, which required the Program Management Office to work with the CHW Advisory Committee and the Department of Public Health to study the feasibility of creating a CHW certification program.

Stakeholders deemed telehealth and recruitment strategies to address workforce shortages in rural areas helpful but insufficient to fully resolve the shortages. Workforce capacity challenges noted in AR2 (e.g., technological issues, regulation, reimbursement) remained in place, although Colorado, Idaho, New York, and Tennessee had some success moving forward with strategies to address the shortages. After a slow start, Idaho funded 12 telemedicine projects fund), established 10 CHEMS programs, and trained 23 paramedics. Idaho also used virtual PCMHs to extend existing primary care resources more efficiently into rural and underserved areas. Although not central to Tennessee’s SIM efforts, some practices in that state adopted telemedicine—with one provider saying patients “love it [because] it’s in the comfort of their home” and that it worked well, especially in rural areas where patients might not have transportation.

Idaho reduced the number of planned telemedicine projects but used the freed-up funds to develop the infrastructure for Project ECHO, a national initiative to mentor PCPs in providing specialty care. Idaho planned to focus initially focus on opioid addiction treatment in primary care settings. New York also adopted Project ECHO and a rural residency program that stakeholders hoped would help address the PCP shortage.

In Tennessee, the state planned to leverage two lottery-funded programs to train direct service workers who provide hands-on assistance with activities of daily living and instrumental activities of daily living needs in home and community-based services and nursing facility settings. Trainees will receive credit toward a certificate and/or degree program beginning in 2019.

“In terms of workforce, one, if we’re going to train people, we have to align the incentives in the right way, for them to want to do the training, and for employers to want to support that training process. We also need to do more than just train, we really need to partner with providers to help them address what has become not just a workforce shortage but really a workforce crisis.”


—Tennessee state official

The success of such strategies as CHEMS, Project ECHO, and rural residency remained to be demonstrated, which—given the pervasive workforce shortages—might not suffice to

cover the needs of rural populations. In Idaho, providers’ lack of awareness of opportunities for billing for telehealth services was recognized by payers as a significant obstacle, as was noted in previous years. In response, the state has formed a workgroup to develop a matrix of reimbursement for telehealth across payers. Feedback from providers during the next reporting period will help stakeholders identify any payment gaps.

2.4 What Progress Have State Innovation Model Round 2 States Made in Population Health Planning and Implementation?

KEY FINDINGS



Progress

- Colorado, Delaware, Michigan, Iowa, Rhode Island, and Washington made significant advances in implementing population health interventions.
- Colorado, Iowa, Michigan, and Rhode Island used SIM funds to put in place infrastructure and processes to coordinate efforts between clinical and community-based entities—to both identify and meet the needs of specific communities. In some cases, states began sharing data for the improvement of clinical quality metrics and population health programs.
- Iowa and Michigan developed and started to operationalize systems (e.g., screening tools, social services platforms) to screen for SDoH and systematically refer individuals to social services.

Barriers

- Community-based organizations lacked a clear and defined process for working with state agencies and navigating bureaucratic hurdles (Delaware and Michigan).
- Lack of a common definition and a shared understanding of population health between and within states resulted in wide variation in the design and implementation of population health interventions (Iowa).
- Delays in accessing and sharing information continue to impede initiatives to address population health needs (Delaware, Michigan, Idaho, and Rhode Island).

In the AR3 analysis period, population health efforts continued to focus on the processes and gains made in implementation but not yet on the outcomes. This section of the report explores states’ progress toward improving the health of its population, the enabling strategies/models implemented, and systemic barriers impeding progress.

More than half the states advanced population health initiatives as part of the SIM Initiative. Colorado, Delaware, Idaho, Iowa, Michigan, Rhode Island, and Washington made significant strides in implementing population health strategies to address community-level needs. Idaho moved ahead on implementing statewide activities to impact its four population health priorities: improving access to health care and reducing diabetes, tobacco use, and obesity. Idaho also, under the auspices of the seven RCs and the Population Health Workgroup, developed a strategic plan to address local needs, such as the opioid crisis. Colorado’s population

health activities focused on behavioral health, with the state conducting statewide stigma-reduction campaigns, community-based training, and agency resource sharing to enhance the impact of the state’s population health activities. Iowa used its locally based coalitions of health and social services stakeholders—C3s—to direct efforts toward reducing such clinical measures as readmissions, ER visits, and some diabetes measures within their specific communities. Washington, with diabetes care and prevention as the focus of its population health activities, launched three initiatives under the oversight of the DOH. Rhode Island launched initiatives in three key areas: high-risk patient identification; tobacco assessment, referral, and treatment; and statewide BMI data collection. Delaware used three Healthy Neighborhoods initiatives to increase awareness of opioids, maternal and child health, and diabetes and obesity reduction through the promotion of healthy lifestyles.

Integrating clinical and community health emerged as the dominant strategy for population health. Five states established infrastructure and built consensus processes to coordinate efforts and to share data and information between clinical and community-based entities, breaking down traditional health care siloes.

RCs in Idaho, C3s in Iowa, CHIRs in Michigan, ACHs in Washington, and Healthy Neighborhoods in Delaware are all *community* collaboratives developed under the aegis of the SIM Initiative. These collaboratives built and strengthened relations among ‘traditional’ suppliers of health care, medical providers, community public health entities, and social service organizations to address the overall SIM goal of improving population health.

“Health is when people leave our clinics or our hospitals, health is when they are in the aisle of the grocery store, or at church potluck or whether it is safe for kids to play outside their homes, in the yard... This is the opportunity to help get our clinicians, who are skilled and good with patients, getting them to understand that it is important to look at health from this population perspective....”

—Michigan provider, FQHC, March 2018

Data access and exchange emerged as a key driver of clinical and community integration and mutually reinforcing facilitator of delivery transformation. Michigan and Iowa exemplified where the states moved beyond collaboration to influence clinical and population health outcomes through operationalizing the real-time sharing of data and information. For example, CHIRs in Michigan developed lists of ‘high-risk’ and ‘high-utilizer’ patients in the region and shared the information with practices to develop a plan to limit and manage inappropriate ER use. Iowa launched a pilot to share ADT feeds with C3s to manage patients appropriately as they transitioned from an inpatient admission back to the community. Rhode Island began planning to pilot the state’s social services database to help providers and CHTs better connect patients to social services.

Another key area of progress in population health was building capacity to address SDoH. Through the CHIRs and C3s, Michigan and Iowa began to use screening instruments for

SDoH. In Rhode Island, state officials conducted a survey of existing approaches to addressing the SDoH needs of high-risk patients and mapped SDoH domains to existing screening protocols. The state’s SIM Steering Committee also fostered connections with a separately funded initiative known as Health Equity Zones, a place-based approach to helping communities come together to “build the infrastructure needed to achieve healthy, systemic changes at the local level.”²² According to state officials, these Health Equity Zones enabled Rhode Island’s SIM Initiative to address the nonclinical determinants of health.

States continued to experience significant barriers in implementing population health strategies. Even as states developed population health activities, a number of cross-

cutting barriers remained. First, broad stakeholder definitions of population health across states and even within states allowed for considerable variation in how SIM interventions were designed and implemented. Where providers defined population health in terms of only the health of their own patient panels, significant components of ‘population health’ happened primarily within clinical settings, in isolation from communities. Second, lack of clear guidance and procedures for community-based organizations to follow in working with state agencies delayed and frustrated collaboration initiatives in at least two states (Delaware and Michigan). Delaware identified this issue as a barrier and established a process for their community partners. Third, delays in accessing and sharing data among partners posed another barrier to population health implementation. In Idaho, for example, RCs and clinics expected to have access to data through the Idaho Health Data Exchange that would allow them to identify and manage population health issues. However, delays in developing data analytics and reporting capacity through the HIE prevented this exchange.

“Community Organizations are not in the business of bureaucracy and they don’t have the resources or time to figure out how to get funding.”

—Delaware state official interview, March 2018

²² Rhode Island DOH. (2018, April). *Health equity zones: Building healthy and resilient communities across Rhode Island*. Retrieved from <http://www.health.ri.gov/publications/brochures/HealthEquityZones.pdf>

2.5 Conclusion: What Key Insights for the Implementation and Sustainability from the Round 2 Model Test States Can Be Gained from Annual Report 3 Findings?



- Alignment of VBP efforts among payers created the traction needed for wider VBP adoption by providers and payers.
- Collective wisdom from payers suggested that the objective of alignment should be to reduce the provider burden and payer costs of administering VBP contracts. Perspectives varied on whether any efforts to align beyond those steps would further APM goals.
- States focused solely on PCMH models might face the most difficulty expanding payer use of shared savings and downside risk in VBP.
- The SIM Initiative or other multi-payer coordinated action might be the best vehicle for coordinating the development of downside-risk contracts.
- Most payment models for primary care, whether SIM-promoted or otherwise, will continue to rely on FFS architecture, posing some unintended consequences for providers.
- Because federal policy largely dominates health care delivery in rural areas, federal guidance could potentially accelerate rural transformation through payment innovation.
- Widespread stakeholder support for ADT alerts suggests a promising strategy for transformation.

Increased alignment of VBP efforts among payers created the traction needed for wider VBP adoption by providers and payers.

In states that recently gained traction in the spread of state-preferred VBP models, payers credited the work of the SIM Initiative in creating better alignment strategies and expected the SIM achievements to drive further progress. Payers described barriers to further market penetration of APMs as arising from the prevailing supply and demand dynamics in fragmented markets discussed above. Some payers described having attempted for years to expand APM

“This would never have happened originally without the SIM grant. We would have had in the marketplace 3 different ACO-like programs from each MCO. At some point in time, that model gives out where each is doing its own, there’s a lot of variation in those models, there is proprietary nature of the models. From a standpoint of provider engagement, the SIM grant has enabled one program, one model, one tool.”

—Tennessee payer

contracting in their provider networks independently and finally recognizing the imperative of coordinated action to reach this objective. Payers also saw alignment as mutually beneficial in reducing their own costs. According to a Tennessee payer, “Alignment across the Medicaid MCOs does help address resource needs in terms of training. Because we’re aligned, all three MCOs don’t need to provide the same training resources to a provider, if the provider is involved with all three. It may help to support sustainability that way.” In Iowa, alignment efforts included the development of a common contract template for all MCOs to use in their VBP contracts with

ACOs. In Rhode Island, Medicaid issued requirements mandating that its Accountable Entities report the measures developed for commercial insurers that are included in the SIM core measure set.

Collective wisdom from payers suggested that the objective of alignment should be to reduce provider burden and reduce payer costs of administering VBP contracts and credentialing practices, but perspectives varied on the value of efforts to align beyond that goal. Many payers interviewed described the importance of finding a shared definition of alignment among stakeholders, such as agreement on objectives and the aspects of APM design and administration that were most important to align. A Connecticut payer characterized this level of alignment as agreement on the “directionality” of APMs. This form of alignment is best represented by Ohio’s Multi-Payer Charters (one for PCMHs and one for EOCs), first established in 2013. Through collaboration with payers, Ohio identified VBP design elements where a standard approach was needed, so payers could align “on principle” and “allow for payer innovation consistent with those principles” and where models could “differ by design.”²³ All four commercial plans in Ohio have since agreed to align VBP contracts with the SIM Initiative “on principle” for a small number of EOCs.

“I think the alignment that the providers need more of now is more congruency across the payers’ programs so they can set up consistent protocols and actually manage to them.”

—Connecticut payer

Some payers believed more alignment than already occurring was needed to expand provider participation and involvement in APMs. For instance, payers frequently acknowledged that providers would be better served by greater uniformity among contracts in measure construction and reporting. As more payment arrangements move to two-sided risk contracts, the stakes will become higher for providers to make choices for maximum impact. For example, new requirements under Medicare’s Quality Payment Program become effective January 1, 2019.²⁴ New incentives for Medicare providers to participate in Advanced APMs might increase interest among a wide range of stakeholders in a new wave of alignment. Iowa’s plans to work with ACOs in the AR4 analysis period to design the next APM, for example, were driven by Medicare: “While we never wanted to be misaligned with Medicare we never sought as direct alignment as what we think we need to achieve now. ... in achieving the other payer advanced APM it’s going to be important to understand how NexGen functions.”

²³ Ohio Governor’s Office of Health Transformation. (2013, October 18). *Episode-based payment charter for payers: Governor Kasich’s Advisory Council on Health Care Payment Innovation*. Retrieved from <https://www.healthtransformation.ohio.gov/Portals/0/20131015%20Episode%20charter.pdf>

²⁴ CMS. (2018). *CY 2019 Updates to the Quality Payment Program*. Retrieved from https://qpp-cm-prod-content.s3.amazonaws.com/uploads/257/2019%20QPP%20Final%20Rule%20Executive%20Summary_FINAL.pdf

Several states—particularly Colorado and Delaware—still experienced what many stakeholders described as a significant amount of uncoordinated payer action, which created excessive burden on providers, unnecessary administrative costs, and general confusion. Payers in Idaho expressed reluctance to align on VBP. In none of these states had payers come to an agreement on the direction alignment should take or the vehicle to get there. Some recognized alignment as key to addressing the market conditions that impeded transformation delivery through VBP, but others did not. However, the burden on providers presented by divergent requirements will likely slow or limit further progress and potentially pose a risk to long-term VBP sustainability.

“if we’re using different tools and metrics and assessing payment in a different way, that is terribly challenging for providers. At some point, are we just going to frustrate them to the point that they don’t want to pay. Are the financial penalties more acceptable than the work that’s required in order to play in this game?”

—Delaware state official

States focusing solely on PCMH models could face the most difficulty expanding VBP that incorporate shared savings and downside risk. Many states focused on expanding PCMH contracting and related supports as the core uniform payment model for payers, frequently beginning with Medicaid. However, the limitations of this approach for moving the health care system away from FFS payment became increasingly evident over the AR3 analysis period. Specialists, hospitals, and long-term care providers together account for most of the country’s health care expenditures. Where these providers were not engaged contractually by payers to contain costs and improve quality, leverage from PCPs on the rest of the system to help them meet the same objectives tended to fall short, as acknowledged occasionally by both payers and SIM officials.

“With a lot of the providers, especially primary care providers, their margins are next to nothing to begin with. One small mistake and they’re out of business.”

—Connecticut payer

While innovative practice partnerships might have increased practice participation in VBP, they generally did so incrementally, with mixed success. Moreover, in markets with many payers competing to recruit practices, none but the largest payers had sufficient negotiating leverage to shift downside risk to PCPs.

Shifting a large share of a state’s health care spending toward two-sided risk became viable, in contrast, when VBP contracts engaged large providers and care systems directly. Throughout the SIM Initiative, large provider organizations demonstrated a greater capacity and willingness than smaller providers to assume accountability for total cost of care and some level of shared savings or risk. Additionally, states that leveraged vertical integration of clinical care—

“[W]e didn’t do all this work just to have an MSSP [Medicare Shared Savings Program] contract. There is a huge infrastructure prepared for value-based payment that’s waiting to be used and engaged.”

—Large provider organization in Delaware

through ACOs, Advanced Networks, or regional quasi-governmental entities—did so almost entirely without SIM funding. Large providers in some places emphasized their current participation in multiple VBP arrangements, for example, and their readiness to take on risk—which states could leverage in SIM-supported purchasing agreements—for Medicaid, state employees, and commercial and employer-sponsored markets. In this manner, several states advanced more rapidly away from FFS payment than other states. In addition, where there had been interruptions in progress—most notably in Iowa—states sounded ready to build on this type of VBP infrastructure for further expansion.

Because federal payment policy dominates the payment landscape of rural America, uniform federal guidance could support and accelerate aligned payment in rural areas.

Strategies that states used to penetrate rural markets under SIM funding included TA for transformation, telehealth initiatives, broadband access support, Project ECHO initiatives, and the training of new and existing workers to reach rural patients. None of these efforts directly addressed APM participation, however. Several states seemed ready to attempt rural practice partnerships in the AR4 analysis period, to enable participation in shared savings models. Although rural practices demonstrated willingness to engage in delivery transformation with intensive support, these efforts seemed unlikely to be sustainable if rural practices did not participate in the prevailing payment models.

In rural America, federal payment policy dominates the payment landscape through Medicare reimbursement and through payment policy for RHCs, FQHCs, and critical access hospitals. Even so, Washington was the only SIM Round 2 state exploring direct negotiation with federal regulators to implement a multi-payer pilot for rural providers. A promising strategy for states with large rural markets might be the development of a uniform federal framework or federal–state partnerships to accelerate rural payment innovation.

Most payment models for primary care, whether SIM-promoted or otherwise, will continue to rely on FFS architecture, posing unintended consequences for providers. SIM work appropriately focused on VBP designs and methods but left unchanged the FFS billing rules that serve as a platform for payment arrangements falling under LAN Categories 1 through 3. System transformation will take place over many years, and alternative payment arrangements are evolving slowly. The provider’s payment landscape during this transition period will sometimes produce conflicting incentives. Moreover, the complexity of system transformation would have made it difficult for states and payers to have anticipated the breadth or depth of consequences for providers. Lack of attention to FFS billing rules has the potential to threaten the financial stability of practices as they undergo transformation or limit the effectiveness of APMs in transforming care delivery.

In at least four states, focus groups of providers and some payers described what they perceived to be a broad misalignment between FFS billing rules and payer objectives for

commercial and Medicaid payers and providers. Examples of such misalignment included capping diabetic education visits; the lack of reimbursement for tests considered evidence-based medicine, such as laboratory tests for high-risk pregnancies; restrictions on who could bill to complete a task; the allowable setting to provide the service; and step therapy and prior authorization requirements.

As mentioned earlier, some states and payers explored FFS billing changes pertaining to care coordination, telehealth, CHWs, and behavioral health services. Further dialogue between payers and providers could help find the right balance between FFS and APMs. Additional inquiry into the financial stability of primary care practices could inform that balance. Practice transformation efforts ask primary care practices to make a host of changes in rapid succession while facing increased uncertainty about future revenue growth and financial stability. To successfully weather this wave of system transformation in delivery and payment, practices must continually balance decisions to invest in their practice infrastructure, hire and train staff, and offer enhanced services to patients—all while having to allocate resources to quality measure submission and analytics review to improve care and reduce cost.

As of the end of the AR3 analysis period, the mix of payments between FFS reimbursement and additional payments practices received through VBP arrangements was sending conflicting messages about delivering care, which potentially complicated practice decision making at every level—for individual patients, in design and adherence to practice protocols, and in wider engagement on delivery transformation.

Current models in some states might need additional resources to meet the high demand for care coordination. Practices faced limited resources for care coordination and patient navigation, yet enhancement of these services was seen as critical for achieving better outcomes for patients. A cross-cutting theme among providers in Colorado and Michigan was concern that demand for care coordination was higher than initially anticipated, causing practices to strain operations to meet the new demand. At the level of treatment, providers described benefits from uniform care coordination protocols that did not discriminate between patients based on their insurer. However, uniform practice protocols were difficult for some providers to execute, for example, when some payers did not support enhanced care coordination but others did. Practices could benefit from more payer guidance in designating these resources. Leaving practices to decide how to manage demand with existing resources risked (1) efficiency loss across the delivery system, (2) less-than-optimal patient outcomes, and (3) poor provider performance in APMs—any or all of which could threaten the post-SIM sustainability of delivery transformation.

Widespread support for ADT alerts suggests a promising strategy for transformation. The four states that advanced alerts through SIM funding (Iowa, Michigan, Tennessee, and Rhode Island) discussed how the SIM Initiative brought standardization to the

participating providers, and consumers noted the benefits of such alerts. In Rhode Island, for example, CMHCs received alerts from hospitals for behavioral health consumers through the CMHC dashboards, which stakeholders reported were reducing inappropriate utilization for patients with complex behavioral health conditions. Additional well-defined initiatives (use cases) could beneficially go beyond ADT alerts and include exchanges of data from medical records to be used by both hospitals and physician practices at the points of care. State progress on these initiatives, however, will require addressing concerns about privacy, data ownership, and costs. In all four states, stakeholders reported that it was challenging and often burdensome to adapt information sharing into clinical workflows.

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3. Conclusion

By the end of the AR3 analysis period, all Round 2 Model Test states demonstrated progress in one or more key areas of transformation—payment reform, delivery transformation, and population health—as states shifted from SIM planning activities, which were the focus of the AR2 analysis period. State strategies reflected the opportunities and constraints of local market conditions, from which emerged implications for future progress and sustainability. Transformative work remained narrowly focused on primary care across Round 2 Model Test states. To advance widespread payment reform adoption, most states chose to support primary care transformation through patient-centered medical home models—well-known to states through pre-SIM efforts. State design choices may hamper the SIM Initiative’s impact on total cost of care, however, because of the limited expected impacts of state health care transformation efforts on high-cost providers (e.g., specialists, hospitalists, long-term care providers).

Nonetheless, other important impacts on quality and utilization are likely to manifest themselves going forward, based on evidence emerging from the AR3 analysis period. Providers perceived great value in care coordination and would welcome additional resources to support it. Moreover, care coordination and population health initiatives to integrate clinical care with community services have been mutually reinforcing. In addition, anecdotal evidence from states suggests that behavioral health integration initiatives increased screening (and treatment when available), despite chronic behavioral workforce shortages. Finally, health information technology initiatives—such as admission, discharge, and transfer alerts—have proven to be important tools to coordinate care and promote better utilization.

The degree to which this progress can be sustained as market conditions evolve will be a major focus of future evaluation reports. The primary goal of AR3 was to synthesize stakeholder perspectives on the overall likelihood that SIM strategies would overcome barriers as intended. AR4 will explore stakeholder experience related to the impact of specific strategies on the health care transformation goals of the Round 2 SIM Initiative.

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Appendix A: State Innovation Model in Model Test States: Colorado

Key Results from Colorado's State Innovation Model Initiative May 2017–March 2018

Strategies, progress, and accomplishments, May 2017–March 2018

- Primary care practices in Cohorts 1 and 2 and community mental health centers (CMHCs) were transforming and integrating care, and preparation for Cohort 3 began.
- Primary care providers (PCPs) with low behavioral health integration reported using the SIM Initiative to begin or improve integration; PCPs with higher integration reported using the SIM Initiative to prepare for value-based payment (VBP) arrangements.
- Multi-stakeholder symposiums provided some help in aligning payer and provider VBP expectations.

Stakeholder response to implemented strategies

- PCPs reported changes in care delivery and significant improvements in behavioral health integration as a result of the SIM Initiative.
- Providers reported positive experiences with practice transformation organizations (PTOs) and clinical health information technology (health IT) advisors (CHITAs).
- CMHCs' "whole-person" approach generated positive experiences for CMHCs and patients.
- Stakeholders believed achieving a preponderance of care would be possible through a combination of multiple initiatives, including Comprehensive Primary Care Plus (CPC+), the Medicaid alternative payment model (APM) initiative, and commercial payer VBP initiatives.
- Some stakeholders expressed concern that fewer Cohort 3 applications in the latest application round suggested slower progress meeting preponderance of care goals and practice change fatigue.

Remaining challenges

- Health IT tools, Stratus, and the electronic clinical quality measure (eCQM) tool have been slow to develop, and/or uptake is low.
- Lack of data hinders Colorado's ability to track progress toward statewide preponderance of care goals.
- A shortage of behavioral health providers, particularly in rural areas, makes integration difficult.
- Primary care and CMHC providers worry about how to show payers the value of integration.

Sustainability after the SIM award

- Providers are concerned their integration efforts will not be sustainable after the end of the SIM Initiative without continued practice facilitation assistance.
- Stakeholders are concerned about the sustainability of population health initiatives that do not show a positive return on investment (ROI).

Colorado’s SIM Initiative began on February 1, 2015. The state sought to use its SIM award to improve the integration of behavioral and physical health and promote provider uptake of VBP.

Colorado’s SIM Initiative Goal
To improve the health of Coloradans by increasing access to integrated physical and behavioral health care services in coordinated community systems, with VBP structures, for 80 percent of Colorado residents by 2019.

This updated overview of the Colorado SIM Initiative is based on an analysis of data collected from site visits,¹ stakeholder telephone interviews, state document reviews, and state program and evaluation calls between May 1, 2017, and March 31, 2018, the Annual Report (AR)3 analysis period. Further details on the analytic approach are available in *Chapter 1*. Information on the number and types of stakeholders interviewed is in *Table 1-1*. *Figure A-1* depicts the timeline of major Colorado SIM Initiative and SIM-related activities to date.

A.1 Key State Context and Progress Prior to May 2017

A.1.1 Pre-State Innovation Model health care in Colorado

Three unique features of the state impact Colorado’s population health and health care environment: (1) a rural population with health care workforce shortages; (2) a highly diverse health insurance market, with no one payer holding a majority of the market; and (3) commercial payer use of VBP. Colorado has a history of experimenting with health care redesign to improve access and quality of care and of public and private payers collaborating on VBP. Prior to the SIM award, Colorado made improving access to and treatment of behavioral health services for all citizens a public health priority.

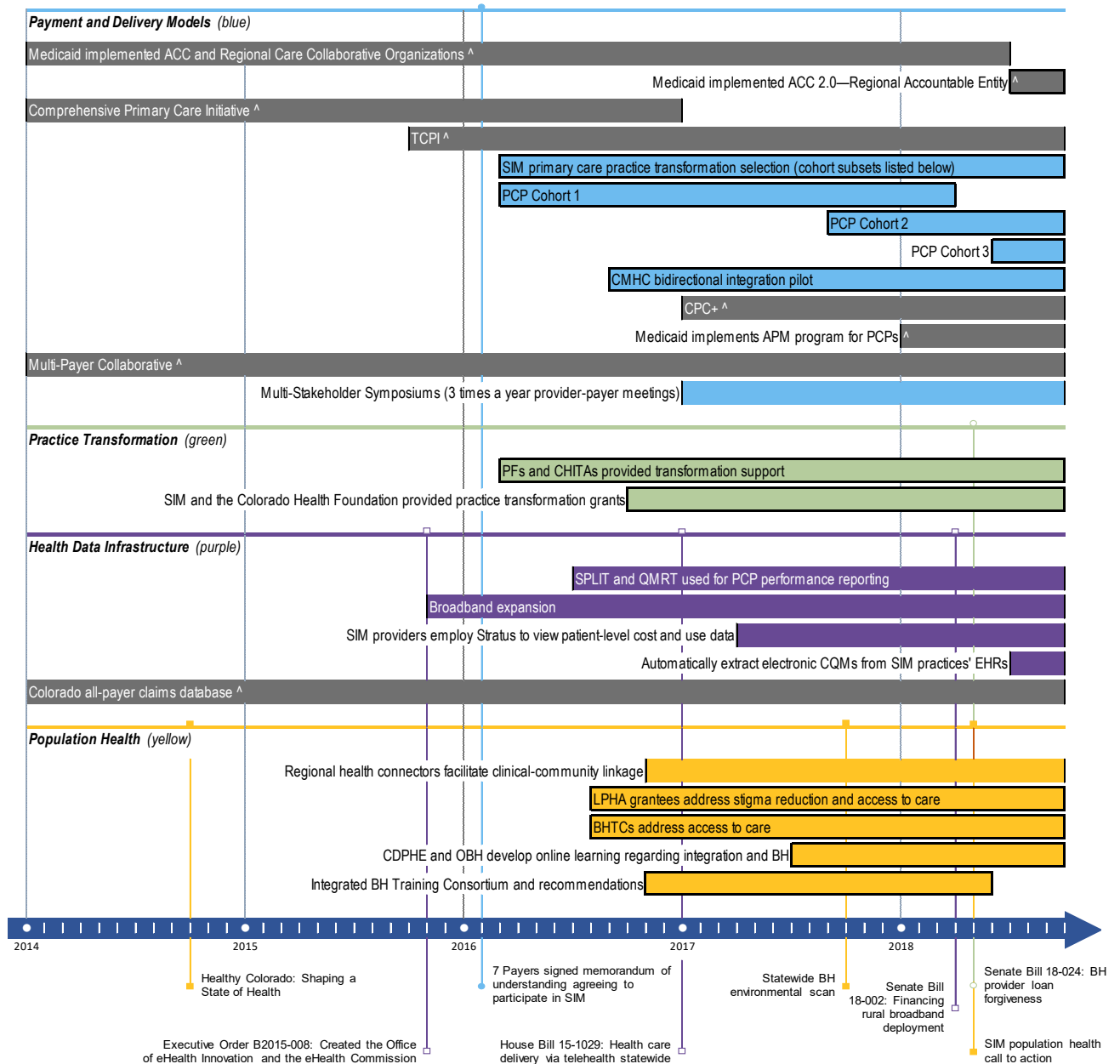
A.1.2 State Innovation Model Initiative progress and changes prior to the Annual Report 3 analysis period

To accomplish its goals, Colorado focused its SIM Initiative efforts on supporting practice transformation within primary and behavioral health care; expanding provider use of data to monitor quality, utilization, and costs; developing health IT systems to facilitate quality measure reporting for VBP; aligning quality measures for SIM-participating practices; improving community awareness of behavioral health issues; and connecting clinical and community supports to advance population health. Colorado placed high value on stakeholder engagement by relying on seven work groups² to meet regularly to identify, discuss, and make recommendations in support of SIM Initiative operations and state-level policy change.

¹ RTI International did not conduct focus groups with consumers because of delays in obtaining contact information for Medicaid consumers before the end of the AR3 analysis period.

² The seven work groups are Consumer Engagement, Evaluation, Health IT and Data, Policy, Population Health, Practice Transformation, and Workforce.

Figure A-1. Timeline of Colorado State Innovation Model and State Innovation Model-related activities



ACC = Accountable Care Collaborative; APM = alternative payment model; BH = behavioral health; BHTC = behavioral health transformation collaborative; CDPHE = Colorado Department of Public Health and Environment; CHITA = clinical health information technology advisor; CMHC = community mental health center; CPC+ = Comprehensive Primary Care Plus; CQM = clinical quality measure; EHR = electronic health record; LPHA = local public health agency; OBH = Office of Behavioral Health; PCP = primary care provider; PF = practice facilitator; QMRT = Quality Measure Reporting Template; SIM = State Innovation Model; SPLIT = Shared Practice Learning and Improvement Tool; TCPI = Transforming Clinical Practice Initiative.

Notes: Gray bars (with ^) denote that the items are not SIM activities or policies but are important for context. Black outlines around color bars denote activities that contribute to integrating primary care and BH.

The Colorado SIM Initiative supports two major delivery system reforms: (1) practice transformation support for up to 400 primary care practices to integrate behavioral health and primary care services and to prepare for VBP arrangements with payers and (2) practice transformation support to four CMHCs integrating primary care into behavioral health. Provider organizations participating in both these reforms receive extensive practice transformation and CQM reporting support and access to claims data to track patient utilization and costs. Colorado spent significant time in the AR2 analysis period aligning practices' SIM quality measures with CPC+ and the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act (MACRA) Quality Payment Program.

Ninety-two primary care practices (known as Cohort 1) joined the SIM Initiative in March 2016, and 154 more practices (Cohort 2) joined in September 2017. Cohort 1 and 2 providers have focused on meeting practice transformation milestones to establish or improve behavioral health integration, engage in clinical quality improvement efforts, and report CQMs. CMHCs experienced delays during the AR1 analysis period but began their transformation efforts in November 2016. Seven payers—six commercial payers and Medicaid—agreed to support SIM-participating primary care practices with a VBP, which could be either a new reimbursement for SIM participation or a VBP the payer already had in place with a practice. CMHCs do not receive SIM-related VBPs. Since January 2017, the state has brought these providers and payers together every several months in a Multi-Stakeholder Symposium to discuss issues around VBP and behavioral health integration.

Finally, by the end of the AR2 analysis period, the state had hired 21 regional health connectors, which connect local organizations and build strategic partnerships to address local population health priorities. Additionally, local public health agencies (LPHAs) and behavioral health transformation collaboratives (BHTCs) funded by the SIM Initiative began activities to address mental health stigma reduction and prevention and screening and referral for treatment.

A.2 Progress and Accomplishments from Colorado’s State Innovation Model Initiative, May 2017–March 2018

A.2.1 Delivery models and payment reforms

Key Results
<ul style="list-style-type: none">• Cohort 2 was launched, and applications for Cohort 3 in Primary Care Transformation were released.• PCPs reported changes in care delivery and improvements in behavioral health integration.• PCPs with low behavioral health integration reported using the SIM Initiative to improve integration. Practices with higher behavioral health integration reported using the SIM Initiative to prepare for VBP arrangements from payers.• Providers’ primary concerns were behavioral health workforce shortages and sustainability.• CMHCs were fully implemented and working toward integration.

Colorado’s SIM Initiative resulted in notable gains in practice transformation and behavioral and physical health integration for the 92 Cohort 1 practices. The Colorado SIM Office also launched 154 new practices in Cohort 2, issued the call for applications for Cohort 3, and continued providing practice transformation technical assistance (TA) for the four participating CMHCs. Colorado made no significant changes during the reporting period to the design or implementation of these delivery system models or to the VBP strategy (*Table A-1*).

Practice transformation model for primary care

PCPs reported that the SIM Initiative was resulting in care delivery changes and better understanding of and progress toward effective behavioral health integration. The SIM Initiative gave participating primary care practices the opportunity to engage in new activities to support behavioral health integration. For example, practices reported obtaining new supplies (e.g., tablets for physical and behavioral health screenings), sending staff to integrated workforce trainings, creating private spaces in their offices for behavioral health clinicians, hiring patient navigators to support care coordination and team-based care, and hiring behavioral health providers.³ In some instances SIM Initiative funding supported these activities, and in other instances, practices invested their

“We really didn’t touch at all on screening for depression or treatment for drug abuse or alcohol and had not even considered putting in a behavioral health person in our office. So, we went from only tracking traditional medical issues to trying to incorporate behavioral health into what we were paying attention to [with SIM].”

—PCP focus group participant

³ SIM funding could not be used to hire staff. The Colorado Health Foundation provided competitive grant funding to SIM-participating practices, and these funds could be used to hire care coordinators or behavioral health clinicians.

Table A-1. Colorado’s progress on delivery system and payment reforms

Delivery system reform	Activity	Target population	Key activities	Progress between May 1, 2017, and March 31, 2018
Primary Care Transformation	Cohort 1	92 primary care practices	<ul style="list-style-type: none"> Integrating BH into primary care Receiving VBP from at least one SIM-participating payer Program start and end: March 2016–March 2018 	<ul style="list-style-type: none"> Continued meeting practice transformation milestones. Completed all practice transformation assessments.
	Cohort 2	154 primary care practices	<ul style="list-style-type: none"> Integrating BH into primary care Receiving VBP from at least one SIM-participating payer Program start and end: September 2017–June 2019 	<ul style="list-style-type: none"> Began working on practice transformation milestones, including establishing or improving BH integration.
	Cohort 3	Anticipated 150 primary care practices	<ul style="list-style-type: none"> Integrating BH into primary care Receiving VBP from at least one SIM-participating payer Program start and end: June 2018–June 2019 	<ul style="list-style-type: none"> Released requests for applicants; 90 primary care practices applied, short of the goal of having enough applicants to fill an estimated 150 slots.
CMHCs	Bidirectional health home pilot	Four CMHCs	<ul style="list-style-type: none"> Integrating primary care into BH No VBP from SIM-participating payers; Medicaid is the primary payer for CMHCs, and thus, CMHCs already receive capitation payments from Medicaid. Program start and end: November 2016–June 2019 	<ul style="list-style-type: none"> Worked on practice transformation milestones, including integrating primary care. Identified target population for integration. Identified quality measures to monitor progress.

BH = behavioral health; CMHC = community mental health center; SIM = State Innovation Model; VBP = value-based payment.

own resources. Some practices—including those that had already integrated some behavioral health services before the SIM Initiative began—used SIM funding to improve the work flow between multidisciplinary teams, increase the use of patient assessments and screenings for behavioral health concerns, create more joint wellness initiatives between physical and behavioral health providers (e.g., diabetes improvement), train behavioral health clinicians on medical issues and medical clinicians on behavioral health issues, and learn how to combine and use physical and behavioral health electronic health records (EHRs) for quality improvement.

The state’s evaluator found that, after 12 months of SIM participation, 42.4 percent of the 92 Cohort 1 participating practices had moved to higher self-reported behavioral health integration compared to their baseline; 38 percent had not changed, but 20 percent had reduced their level of integration compared to their baseline. Part of the latter trend was because, as practices learned more about what an integrated practice is and what is required at each

integration level, some practices concluded that they had previously overstated how integrated the practice had been at baseline. This realization led them to evaluate themselves as less integrated at 12 months than at baseline. Practices with high visit volume, that were nonurban practices, and/or that were family practice specialist practices trended toward an increase in higher integration compared to other practice types from baseline to 12-month follow-up; however, other practice types were also improving their levels of integration.⁴

Several practices expressed enthusiasm for the SIM practice transformation milestones as a guiding framework for how to make practice improvements.⁵ SIM [check mark] quality measures also guided PCPs' quality improvements in work flow and care delivery. For example, PCPs credited SIM participation with increasing their offices' screening rates for social needs, depression in adolescents, and drug/alcohol abuse.

PCPs with low behavioral health integration used the SIM Initiative to begin or improve integration. Those with higher behavioral health integration used the SIM Initiative to prepare their practices to meet performance and reporting expectations associated with VBP arrangements from payers. Primary care practices that did not have behavioral health integration in place, for example, benefited from TA that helped them establish referral networks or co-locate a behavioral health provider. This phenomenon was particularly true for rural practices, many of whom saw any behavioral health integration as valuable given the dearth of behavioral health providers in rural areas of the state.

"SIM has really helped, I believe, open up the whole clinic's eyes about the need for behavioral health awareness, especially up in a rural mountain community."

—PCP focus group participant

"I think it's getting us ready for the future... With the rollout of the alternate payment models, we're starting to get our ducks in a row and starting to get on creating reports so that we can get enhanced payment in the future"

—PCP focus group participant

Primary care practices that already had a co-located behavioral health provider or well-established referral networks with behavioral health providers used the SIM Initiative to focus more energy on learning to track the clinical and utilization data expected under VBP arrangements.

⁴ TriWest. (2017, October 27). *Colorado State Innovation Model Evaluation: Quarterly Report, April–June 2017*. Retrieved from <https://drive.google.com/file/d/1Yf7H05qXARhU7wE1tlzBV2nu7J0EQ9Xk/view>

⁵ The SIM milestones, which reflect common attributes of high-performing primary care practices, are organized based on a well-recognized framework, Bodenheimer's "10 Building Blocks of High-Performing Primary Care". More information on the milestones can be found at <http://resourcehub.practiceinnovationco.org/wp-content/uploads/2017/11/SIM-Framework-and-Milestones.pdf>

Some behavioral health providers working within primary care practices saw the SIM Initiative as primarily a vehicle for PCPs to improve quality and prepare for VBPs and less as a support for behavioral health clinicians working to improve care in primary care settings.

Providers said a primary issue was the inadequate supply of trained behavioral health workers. Several practices and payers observed that relatively low wages, particularly in rural areas, made it difficult to recruit and retain behavioral health clinicians. Adding to the recruitment challenges some providers faced was that integrated settings require a different set of skills than is traditionally taught to behavioral health providers. Recognizing these workforce issues as a key barrier to behavioral health integration within the state, the Colorado SIM Initiative helped area universities secure federal grant funding to train providers to work in integrated settings, and SIM Workforce Work Group members are providing thought leadership on program implementation (see *Section A.2.3* for more details). The Colorado SIM Initiative has also funded education efforts to train more providers to work in integrated, team-based settings (see *Section A.2.3* for more details).

Providers described difficulties in bringing the primary care culture and behavioral health culture together into one clinical practice. For example, some practices observed that primary care and behavioral health clinicians did not have similar views on the amount of time to spend with patients. Behavioral health providers expected to spend more time per patient than PCPs allocated, while PCPs wanted behavioral health clinicians to see more patients per day. Other practices gave examples of the lack of shared understanding between provider types on the impact of behavioral health issues on clients' ability to participate in self-care and the importance of shared decision making.

“Not everyone buys in and we have had some culture challenges, which everyone has, and happens when you are trying to merge a medical culture with a behavioral health culture.”

—PCP

“When we talk about cultural things, it is kind of like we don't understand each other's jobs.”

—PCP

Bidirectional health home pilot

CMHCs provided an integrated whole-person care approach they believed resulted in positive patient experiences. Interviewees gave several examples of how they were making practice improvements to better integrate primary and behavioral health care to advance whole-person care under the bidirectional pilot. For example, in one CMHC that wanted to use the SIM Initiative to improve care for diabetic patients, the practice facilitator (PF) taught behavioral and physical health clinicians how to work together on shared care plans to help patients improve glucose control.

CMHCs were nonetheless concerned that they did not have good quality metrics for integration and whole-person care within a behavioral health setting. Without good quality

metrics, CMHCs said they may not be able to demonstrate the value of behavioral health integration to payers.

Value-based payment strategy and payment reform

Colorado held three Multi-Stakeholder Symposiums during the AR3 analysis period that stakeholders generally saw as helpful forums to discuss VBP priorities and challenges. PCPs continued to report frustration over the lack of standard SIM VBP from SIM-participating payers for their behavioral health integration work. Nevertheless, some providers, payers, and state officials were optimistic that the symposiums would enable participants to reach an understanding of (1) what payers want to support through VBP and (2) what providers need to demonstrate to successfully enter into a VBP arrangement. However, other interviewed providers were ambivalent or slightly negative about the forums, questioning whether these forums would lead to actionable change and mutual understanding between providers and payers. Further, some state officials and payers acknowledged that misaligned expectations still existed between providers and payers around what makes a practice eligible for VBPs and expressed the hope that future symposiums would clarify any such misperceptions.

Ongoing conversations among state officials, payers, providers, primary care practices, and CMHCs led to an agreement that providers want and need more training, specifically in how to extract and use their clinical and financial data to show the ROI for primary and behavioral health integration and subsequently negotiate new reimbursement models with payers. The SIM Office expects to provide this training in future SIM years.

Consumer Engagement
To stimulate consumer engagement, Colorado will interview community members in two underserved regions of the state to learn about their health care experiences during spring 2018. An estimated 25 individuals will then be trained on how to participate in work groups and provide the consumer voice in local health care transformation efforts.

Sustainability

Some PCPs and CMHCs were concerned that their integration efforts will not be sustainable after the SIM Initiative ends. Because demonstrating increased integration and continued quality improvement is critical for payers considering making VBPs, the SIM Office would like these activities to continue after the SIM Initiative ends. However, some PCPs and CMHCs expressed concern that continuous quality improvement takes staff time, effort, and TA, and providers, especially those who rely on PFs for help, doubted their ability to sustain these activities after SIM funding ends. Retaining a behavioral health provider or continuing effective collaboration with an external behavioral health provider also requires adequate reimbursement from payers. Some practices and CMHCs questioned whether all these activities can be sustained without SIM support, including PFs to help practices with billing/reimbursement for behavioral health clinicians and small grants to support behavioral health clinicians' salaries.

Because each CMHC built a unique organizational structure to meet its own integration needs, the SIM Office was optimistic about CMHC sustainability. The SIM Office was hopeful that each CMHC had designed an approach that they believed could be sustainable in the long run. The SIM Office also expected each of the four CMHCs to draft a description of its integration approach to provide four unique pathways to integration that other CMHCs in the state could follow.

Upcoming changes in Medicaid were a concern for PCPs and CMHCs. SIM-participating practices that served Medicaid beneficiaries faced additional delivery system change during the AR3 analysis period. Colorado Medicaid was planning the Accountable Care Collaborative (ACC) phase II, which was to launch in July 2018. Under ACC II, seven Regional Accountable Entities will be responsible for managing both the physical and behavioral health care of Medicaid enrollees. The Medicaid program and the SIM Office were in close coordination about how to align the SIM Initiative and ACC program throughout the AR3 analysis period. Even so, PCP and CMHC interviewees expressed concern about (1) how reimbursement for behavioral health services in integrated care settings would change under the ACC and (2) whether these changes would undo or halt progress in integrating behavioral health clinicians and primary care.

A.2.2 Progress toward a preponderance of care in value-based payment and alternative payment models

Key Results
<ul style="list-style-type: none"> • The multi-payer collaborative and alignment with Medicaid and Medicare programs facilitated progress toward preponderance of care. • The state made some progress toward statewide preponderance of care goals. • A lack of reported data hindered Colorado’s ability to track progress toward statewide goals.

Colorado increased provider and patient participation in the SIM Initiative and made progress toward its goal of having 80 percent of Colorado residents in integrated, coordinated community systems with VBP structures. Despite making progress toward the 80 percent preponderance of care goal, state officials, partners, and payers agreed that 80 percent is very ambitious for the SIM Initiative to achieve.

When interviewees considered expanding the focus of the 80 percent goal to include the CPC+, Colorado’s Medicaid rollout of a new APM for Medicaid PCPs, and the increasing use of VBP among commercial payers, state officials became more positive that the 80 percent goal might be attainable. The multi-payer collaborative continued

“I feel like too there’s a lot of work being done in the state of Colorado that is outside SIM—other initiatives that are also focused on alternative payment models. So, SIM may not get to 80 percent, but I think Colorado is going to be at 80 percent. It may be close to that now, with all the different initiatives.”

—State official

to be a strategic avenue through which payers meet regularly to discuss alignment of the different initiatives supporting the spread of VBP throughout the state.

Stakeholders warned that waning interest in the SIM Initiative among primary care practices may negatively impact progress. Several state officials reported that having six payers participating in the SIM Initiative conveyed that SIM participation was a worthwhile investment for PCPs. Nonetheless, several state officials, consumer advocates, and payers felt that the fewer-than-anticipated Cohort 3 applications may reflect participation fatigue (i.e., practices tiring of participating in yet another new initiative) and/or resistance to change among the practices that have so far resisted applying for SIM participation.

Table A-2 presents the extent to which Colorado’s population is participating in the SIM payment and health care delivery models. This was the first time Colorado reported these data, which the state provided in its Award Year 3, Report 2 to CMMI.⁶ Since the February 2016 launch of Cohort 1 practices in Colorado’s primary care practice transformation initiative, the number of Colorado residents attributed to these participating practices has been approximately 320,000. The state has not yet reported the total number of individuals attributed to Cohort 2 practices, which launched in September 2017; thus, the enrollment numbers reported below reflect Cohort 1 enrollment only. The number of Colorado residents attributed to the bidirectional CMHC health home initiative is relatively small (4,541) because only four CMHCs participated, and the attributed patients were those with serious mental illness who were also receiving primary care services either at the CMHC or the PCP partnering with the CMHC for the behavioral health pilot.

Table A-3 presents the number of Colorado’s providers participating in the SIM payment and health care delivery models. As of Award Year 3, Report 2, 246 primary care practices (92 in Cohort 1 and 154 in Cohort 2) with 1,855 providers were participating in the primary care practice transformation to integrate behavioral health, and four CMHCs with 79 providers were participating in the bidirectional health home pilot. With the addition of Cohort 2 in September 2017, Colorado has seen the number of participating primary practices increase by 66 percent (from 92 practices to 154), and the state has achieved 62 percent of its goal to enroll 400 primary care practices in its practice transformation initiative. In 2016, Colorado met its goal of enrolling four CMHCs, and there was no change in CMHC participation during the AR3 analysis period.

Table A-4 presents the extent to which Colorado payers participated in VBP or APMs as defined by the Learning and Action Network categories. Four SIM-participating payers submitted baseline data (February 2015–January 2016) during this analysis period; three SIM-participating payers did not report any data.

⁶ These data were not verified by CMMI. Thus, the RTI team cannot attest to their accuracy.

Table A-2. Populations reached by a value-based payment or alternative payment model in Colorado, latest reported figures as of Award Year 2, Annual Report and Award Year 3, Report 2

Payer type	SIM models		Landscape
	BH integration	SIM Initiative-wide	Any VBP or APMs
Statewide (all payers)	325,132 ¹ (6.1%)	325,132 ¹ (6.1%)	—
	4,541 ² (0.1%)	4,541 ² (0.1%)	

Source: Colorado SIM Award Year 3, Report 2 Metric Template

— = relevant data not provided in the data source; APM = alternative payment model; BH = behavioral health; CMHC = community mental health center; SIM = State Innovation Model; VBP = value-based payment.

¹ This value is the number of individuals enrolled in the primary care practice transformation initiative (through 92 primary care practices) and reflects data submitted for Award Year 3, Report 2.

² This value is the number of individuals enrolled in Colorado’s SIM CMHC initiative (through four CMHCs) and reflects data submitted for Award Year 2, Annual Report.

Note: The denominator (total state population, totaling 5,359,295) was provided by the United States Census Bureau American Community Survey 5-Year Estimate 2012–2016

(<https://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml>; accessed May 31, 2018).

Colorado reported that it had reached 24% of its target enrollment in the primary care practice transformation initiative and 91% of its target enrollment in the CMHC initiative.

Table A-3. Providers participating in a value-based payment or alternative payment model in Colorado, latest reported figures as of Award Year 3, Report 2

Provider type	SIM models		Landscape
	BH Integration	SIM Initiative-wide	Any VBP or APMs
Providers	1,855 ¹ 79 ²	1,855 ¹ 79 ²	—
Provider organizations	246 ¹ 4 ²	246 ¹ 4 ²	—

Source: Colorado SIM Award Year 3, Report 2 Metric Template

— = relevant data not provided in the data source; APM = alternative payment model; BH = behavioral health; CMHC = community mental health center; PCP = primary care provider; SIM = State Innovation Model; VBP = value-based payment.

¹ Total number of PCPs/primary care practices participating in the BH integration model.

² Total number of CMHC providers/CMHC provider organizations participating in the BH integration model.

Table A-4. Payers participating in a value-based payment or alternative payment model in Colorado, latest reported figures as of Award Year 1, February 2015–January 2016

Payer	Category 1 Payment: Fee-for-service with no link of payment to quality		Category 2 Payment: Payment linked to quality		Category 3 Payment: APMs		Category 4 Payment: Population-based payment	
	Number of beneficiaries	Percentage of payments	Number of beneficiaries	Percentage of Payments	Number of beneficiaries	Percentage of payments	Number of beneficiaries	Percentage of payments
Medicaid	—	—	117,982	—	75,472	—	—	—
Commercial Payer 1	—	—	—	—	—	—	7,529	100%
Commercial payer 2	—	—	—	—	11,491	100%	—	—
Commercial payer 3	6,156	—	—	—	10,713	—	9,293	—

Source: Colorado SIM Award Year 3 Report 2 Metric Template.

— = relevant data not provided in the data source; APM = alternative payment model; SIM = State Innovation Model.

State officials reported that obtaining data from participating payers remains challenging. Despite spending significant time discussing data needs, state officials said payers did not view sharing data as a priority (particularly large national payers) and reported challenges in finding knowledgeable payer staff to provide the information. Some state officials also observed that the time spent with payers on reporting data detracted from the time available for meaningful conversations about payer alignment to support VBP and behavioral health integration.

A.2.3 Enabling strategies to support health care delivery transformation

Key Results
<ul style="list-style-type: none"> Stakeholders found that practice transformation assistance improved practice efficiencies and the effective use of data. E-learning opportunities and Collaborative Learning Sessions were conducted to help practices share best practices, identify lessons learned, and transform their workforce. Health IT and data aggregation tools and platforms were developed and refined to help providers monitor transformation, use, cost, and quality and to submit eQMs. Uptake of the data aggregation tool, Stratus, was low because it was deemed not useful. Information sharing between primary care and behavioral health providers remained a challenge. Quality measure alignment across different initiatives continued to be positively received by practices.

Practice transformation

The central focus of SIM practice transformation efforts included helping practices coordinate practice changes and aligning SIM activities with other delivery system reform initiatives. Both state officials and provider interviewees saw SIM-supported practice transformation assistance as a “heavy lift” and a success (*Table A-5*).

Table A-5. Colorado’s progress on enabling strategies to support health care delivery transformation

Activity	Target population	Key activities	Progress between May 1, 2017, and March 31, 2018
PTOs providing practice facilitation	SIM-participating primary care practices and CMHCs	Wide array of practice transformation assistance, including helping practices meet practice transformation milestones	<ul style="list-style-type: none"> Continued to offer practice facilitation to Cohort 1 practices and began assisting Cohort 2 practices and CMHCs. PTOs participated in training and office hours.
CHITA	SIM-participating primary care practices and CMHCs	Health IT and data analytics assistance	<ul style="list-style-type: none"> Continued providing analytical assistance to identify data for quality measures.
Practice transformation small grants	SIM-participating primary care practices	Funds used to upgrade practice technology, train staff to better coordinate with and refer to BH providers, support family and patient engagement, and seed fund behavioral health clinicians’ salaries	<ul style="list-style-type: none"> 40 Cohort 2 practices received a grant.

BH = behavioral health; CHITA = clinical health IT advisor; CMHC = community mental health center; health IT = health information technology; PTO = practice transformation organization; SIM = State Innovation Model.

Providers were generally very pleased with the assistance they received from PFs and CHITAs. PFs provided practices with TA that helped meet practice transformation milestones. For example, PFs helped practices improve care continuity, practice communication and patient flow, the identification and development of quality improvement projects, and patient risk stratification. PFs also helped primary care practices identify and implement new programs (e.g., screening programs) and tools (e.g., shared care plans) that integrate behavioral health. Some practices that worked with PFs from multiple initiatives (e.g., CPC+, Transforming Clinical Practice Initiative [TCPI]) viewed the PF services as duplicative, but others felt that these services enhanced practices’ ability to address transformation challenges and streamline processes across multiple initiatives.

Providers reported that the CHITAs helped them to mine data to track patient utilization over time, generate quality measure and utilization reports from EHRs, and ensure accurate reporting of CQMs. Most providers viewed the CHITAs as helpful in obtaining data from primary care practices' EHRs. Interviewed CMHCs reported relatively minimal contact with their CHITAs and had little to say about how the CHITAs are being used or the benefit they provide.

Because practice transformation and health IT assistance needs varied greatly across practices, PFs and CHITAs tailored their support to individual practices' needs.

Some practices began practice transformation through another initiative (e.g., CPCi, TCPI, commercial payer initiative) before joining the SIM Initiative. These practices leveraged key infrastructure, staffing, and work flow processes to enhance behavioral health integration efforts under the SIM Initiative. Other practices were either new to practice transformation and health IT assistance and/or not fully engaged in the process of practice transformation (and, thus, required more assistance to get started on the transformation process).

State officials and PTOs viewed continual training as key to sustaining the success of the PTO and CHITA workforce.

The SIM Office continued to use training days and PTO office hours to train and develop this new workforce. The PTOs found some trainings helpful, but others judged the trainings as too basic to be useful. The PTOs wanted more training on how to use the new Shared Practice Learning and Improvement Tool (SPLIT) and to have all trainings recorded so that trainees could participate at more convenient times. At the request of some providers and state officials, future PTO trainings will include a stronger focus on helping practices better understand business operations (e.g., how income and revenue flow through the practice, how to bill more efficiently) to assist practices in negotiating VBP contracts with commercial payers.

"I think that she's [practice coach] been great in just helping us... When I say SIM is not a burden, the reason it's not a burden is because our CHITA and our practice coach have worked with us."

—PCP

"I would say that that has been one of the most positive things—the practice coach. It's been super helpful to help us pick small doable QI [quality improvement] goals and to work on them and then come back and review them and either keep working or move to the next one. Our practice coach has been really helpful at that."

—CMHC provider

"I think [SIM practices] are along the spectrum right now. I think we have a number of practices that are there, that have the infrastructure, that have created the changes, that have been doing this work for many years. But then we have some practices that have never looked at this in a different way, have never engaged in this work."

—PCP

Practices described the practice transformation small grants program as extremely helpful for a wide range of operational enhancements.⁷ For example, some practices used their grant for physical upgrades, such as adding a behavioral health provider office. Others used these funds to improve their care delivery processes, including by purchasing items such as teleconference software to improve communication between PCPs and off-site behavioral health clinicians or hiring a certified coder to improve practice billing.

Despite practice transformation activities, some practices still struggled with the administrative and practical problems associated with implementing an integrated behavioral health practice. Practices shared challenges, such as coordinating behavioral health services within a primary care practice and finding ways to facilitate care transitions or “warm hand-offs.” Unlike in primary care, where patient appointments are scheduled in 15-minute slots, and a provider can easily provide a quick consult or patient review, behavioral health appointments are scheduled for 40–60 minutes. Thus, when PCPs identify a patient with behavioral health needs, the patient often has to wait for a hand-off until the behavioral health provider is available. Other practices described needing help with billing payers for a co-located behavioral health provider’s services.

Workforce development

Colorado’s SIM Initiative provider education efforts continued to focus primarily on providing behavioral health providers and PCPs the training and tools they need to work together in a team-based, coordinated care environment (*Table A-6*). Colorado’s SIM Office has focused less on addressing behavioral health workforce shortages, but members of the SIM Workforce Work Group did support one local university’s efforts to address this issue.

As of March 2018, nine SIM-funded e-learning modules became available online to train providers on topics pertaining to integrated care settings. These modules provide training to primary care and behavioral health providers on (1) substance use disorders, including opioids and Screening, Brief Intervention, and Referral to Treatment; (2) psychological trauma in integrated care team settings; (3) psychotropic medication for children and adolescents; (4) depression, distress, and anxiety; and (5) other topics relevant to behavioral health in an integrated care setting. The state became able to track who registers for and completes the modules, but provider uptake is not as robust as state officials would like. Providers can earn continuing education credits for some modules, which some state officials hope might improve uptake in the future.

⁷ Colorado’s SIM Initiative small grant program included funding from Colorado’s SIM grant and funding from the Colorado Health Foundation (CHF). CHF funding could be used for activities or purchases not allowed by the SIM funding.

Table A-6. Colorado’s progress on workforce development

Activity	Target population	Key activities	Progress between May 1, 2017, and March 31, 2018
e-Learning Modules	SIM-participating primary care practices and BH providers [†]	Training providers on topics relevant to BH, BH integration, and team-based care	CDPHE and OBH developed and released three new provider education modules.
Learning Collaboratives	SIM-participating primary care practices and CMHCs [†]	Peer-to-peer sharing of practice transformation best practices, challenges, and lessons learned for clinical staff, office managers, care coordinators, and regional health connectors	Continued to provide Collaborative Learning Sessions, along with e-learning Webinars; expanded collaborative sessions to include Cohort 2 primary care practices; and launched a behavioral health collaborative for CMHCs.

BH = behavioral health; CDPHE = Colorado Department of Public Health and Environment; CMHC = community mental health center; OBH = Office of Behavioral Health; SIM = State Innovation Model.

[†] Modules are online and available to all practices in CO.

Peer-to-peer practice transformation sharing continued through Collaborative Learning Sessions for Cohort 1 and 2 practices and CMHCs. Collaborative Learning Sessions focus on practice transformation and bring together SIM practices to share best practices and identify lessons learned related to practice transformation. In second quarter 2018, 170 providers participated in an e-learning module session and/or a Collaborative Learning Session.⁸ Provider interviewees had a generally positive impression of these learning sessions, although some providers found that the sessions were not necessarily helpful because participating practices were at such different levels of integration that the information conveyed was too rudimentary for some providers’ learning needs. Some CMHCs also observed that these sessions were not very useful for CMHCs because the sessions were designed for primary care practices.

To complement the provider education modules, Colorado’s SIM Initiative partnered with other agencies that could deliver additional training to providers. The SIM Office supported the University of Denver’s Graduate School of Social Work’s successful Health Resources and Services Administration’s Behavioral Health Workforce Education and Training Program grant. Under this grant, social workers will be trained to address behavioral health needs in rural and medically underserved areas of Colorado. SIM Workforce Work Group members will also advise university staff on program implementation throughout the remainder of the training grant. Moreover, the SIM Office partnered with the University of Denver to hold

⁸ These 170 providers do not represent a unique count of providers participating in educational efforts because a single provider could participate in multiple education efforts in the same reporting period. Source: Colorado SIM Fourth Quarter 2017 Metric Template

the Integrated Behavioral Health Symposium in February 2018, which brought together stakeholders to discuss behavioral health workforce issues, including the needs of rural communities, training and education, and sustainability of integrated behavioral health.

Health information technology and data analytics

Colorado continued to expand the state's health IT and data analytics investments to help practices review and report utilization, quality, and practice transformation data (*Table A-7*). The SIM Office also solidified its contract with the Colorado Regional Health Information Organization, one of Colorado's two health information exchanges, to begin building a data solution to transmit practices' CQM data to a central data warehouse. The development of a telehealth strategy remains an ongoing challenge.

The Colorado SIM Initiative updated tools and platforms to help primary care and CMHC providers monitor practice transformation, use, cost, and quality. Responding to PTOs' and practices' requests to make SPLIT more user friendly, Colorado spent considerable time revising the tool, with plans to launch SPLIT 2.0 in summer 2018. The PTOs also requested additional training on how to use SPLIT 2.0, and these trainings will begin in summer 2018.

Populating Stratus with the correct claims data continued to be a substantial challenge for state officials and payers. Negotiating licenses for all practices and acquiring SIM-participating payers' claims data to upload into the tool took significant time and effort. During the AR3 analysis period, the Colorado Department of Health Care Policy and Financing was not submitting up-to-date Medicaid claims data to Stratus because the onboarding of a new data vendor led to data processing delays. The SIM Office formed the Stratus Work Group and began Stratus training Webinars for practices and PTO staff to help practices more effectively use and provide feedback about the platform. Despite these efforts, many providers had not yet begun using Stratus during the AR3 analysis period, stating that the data were often inaccurate, were difficult to integrate in a daily practice workflow, and only gave a partial view of a practice's patient panel.⁹ Without current Medicaid data, practices with a large number of Medicaid enrollees (e.g., Federally Qualified Health Centers [FQHCs], pediatric practices) did not find Stratus useful. One commercial payer questioned the utility of the tool because Stratus duplicates payer-designed platforms that already provide practices with beneficiary-specific and aggregate data on health care use, quality, and costs.

⁹ Payers agreed to provide claims data for individuals attributed to the VBP arrangements they use to support practices under the SIM Initiative. Payers do not provide claims for all of a practice's patients enrolled with the commercial payer. Therefore, a practice can only see the claims data for a portion of their patients.

Table A-7. Colorado’s progress on health information technology

Activity	Target	Key activities	Progress between May 1, 2017, and March 31, 2018
SPLIT	SIM primary care practices and CMHCs	Tool for SIM practices and CMHCs to report progress in meeting practice transformation milestones and collect quality measures quarterly to the SIM Office	<ul style="list-style-type: none"> Upgraded the tool and launched SPLIT 2.0.
Stratus	SIM practices	Platform to view patient-level cost and utilization data from SIM-participating payers’ claims data. Practices are only able to view data for patients attributed to the VBP used by the payer to support the SIM practice.	<ul style="list-style-type: none"> Gave Cohort 2 practices access to Stratus, and Cohort 1 practices-maintained access. Put all SIM-participating payers’ data into Stratus; Medicaid data were originally included in Stratus but were not current. Launched a Stratus Practice Work Group and held Stratus training Webinars.
Feedback reports	SIM-participating practices and CMHCs	Site-specific reports enabling practices to review costs and utilization for SIM-attributed patients	<ul style="list-style-type: none"> Distributed reports to practices and CMHCs each quarter.
eCQM reporting	All state medical practices	Automatic extraction of select CQMs from EHRs and their upload into a central data warehouse	<ul style="list-style-type: none"> Released a contract to Colorado Regional Health Information Organization, one of the state’s health information exchanges, to begin building the eCQM platform. Created data governance around a statewide eCQM data warehouse.
Colorado health IT roadmap	All state medical practices	SIM contributing to the Office of eHealth Innovation’s statewide roadmap to build a platform for the electronic submission of CQMs and to support BH data-sharing and broadband initiatives	<ul style="list-style-type: none"> Released a health IT roadmap in November 2017.
Telehealth/e-consults	All state medical practices	Strategy under development	<ul style="list-style-type: none"> To collect information to support strategy development, Colorado’s SIM Office <ul style="list-style-type: none"> conducted a survey of use of and barriers to telehealth/e-consults among SIM practices; and partnered with Medicaid on an information request about telehealth use among providers, payers, and patients/patient advocacy groups.
Expanding broadband services	All state health care sites	Statewide initiative to expand broadband services to health care sites	<ul style="list-style-type: none"> Connected 220 health care sites to broadband services since the SIM Initiative began.

BH = behavioral health; CMHC = community mental health center; CQM = clinical quality measure; eCQM = electronic clinical quality measure; EHR = electronic health record; health IT = health information technology; SIM = State Innovative Model; SPLIT = Shared Practice Learning and Improvement Tool; VBP = value-based payment.

To ease provider reporting burden and facilitate participation in VBP arrangements, the SIM Office launched a contract to automate the extraction of eCQM data from providers' EHRs and transfer the data to a data warehouse. State officials viewed this process as a SIM investment that could be a valuable support for VBP in the state. Automatic processing would relieve providers of the time-consuming task of submitting EHR-derived quality measures to multiple payers to meet VBP reporting requirements, thereby making VBP arrangements more attractive to providers.

Colorado began planning for telehealth as a means of improving access to behavioral health services and integrated care. The SIM Office began the process with information gathering—convening a subject matter expert group to discuss telehealth strategy, conducting a survey of use of and barriers to telehealth/e-consults among SIM practices; and partnering with Medicaid on a statewide request for information from Colorado's providers about telehealth. However, there was little consensus regarding the utility of pursuing another telehealth pilot within the state because Colorado already had a number of ongoing pilots. Therefore, after extensive discussions with subject matter experts and the Colorado Medicaid office and a review of the survey results, the Colorado SIM Initiative decided to partner with Colorado Medicaid to focus on expanding eConsult networks to rural and underserved areas with a higher percentage of Medicaid patients. By the end of the reporting period, a strategy to do this was under development.

Information sharing between primary care and behavioral health providers remained a challenge. SIM-participating practices frequently cited federal regulations guiding patient confidentiality on substance use treatment (i.e., 42 CFR Part 2) as a major impediment to data sharing. To address this challenge, the SIM Office reached out to partners in the California Office of Health Information Integrity who have experience providing guidance to providers on the confidentiality issue through their State Health Information Guidance (SHIG). These key stakeholders collaborated to provide a list of recommendations to the Colorado Governor's office to help providers navigate these regulations. Stakeholders noted that another impediment to data sharing was the incompatibility between medical and behavioral health EHR systems. Some providers reported success in using their PF and/or CHITA to troubleshoot and provide work-arounds for this issue.

Quality measure alignment

The state continued conversations with commercial and public payers about the benefits of measure alignment for reducing provider burden related to participating in APMs (*Table A-8*).

Table A-8. Colorado’s progress on quality measure alignment

Activity	Target population	Key activities	Progress between May 1, 2017, and March 31, 2018
Alignment of CQMs across initiatives	SIM Practices	Emphasis on measure alignment across SIM and other reform and payment initiatives, such as the CPC+, Colorado Medicaid ACC, Colorado Medicaid primary care payment reform alternative payment model and MACRA	Continued discussions with payers in the multi-payer collaborative about the benefits to practices of aligning measures and measure specifications across payers.

ACC = Accountable Care Collaborative; CHIP = Children’s Health Insurance Program; CMHC = community mental health center; CPC+ = Comprehensive Primary Care Plus; CQM = clinical quality measure; MACRA = Medicare Access and CHIP Reauthorization Act of 2015; QMRT = Quality Measure Reporting Template; SIM = State Innovation Model.

SIM-participating primary care practices and CMHCs reacted positively to quality metric submission requirements because they saw the requirements as necessary preparation for VBP arrangements. Most practices reported that PF and CHITA assistance made submitting quality measure data via the SPLIT 2.0 tool easy. Despite this support, however, some Cohort 1 and 2 practices described challenges in obtaining accurate and complete data (both numerators and denominators) from their EHRs because practice staff and/or CHITAs were unfamiliar with how to make the modifications within the EHR necessary to abstract the relevant data.

SIM has consistently aligned practice’s quality metrics with Colorado Medicaid. With the rollout of Colorado’s ACC Phase II and the ACC’s primary care payment reform program that provides an alternative payment model to Medicaid participating primary care practices, the state has continued to focus on ensuring that practices involved in both the SIM Initiative and ACC 2.0 will have aligned metrics.

Sustainability

Stakeholders voiced uncertainty about the sustainability of many enabling strategies. The SIM Office charged its work groups to begin devising plans for sustaining SIM activities, and thus, more will be known about sustainability plans in the next analysis period. However, the development of the eCQM tool will continue. SIM practices also participating in CPC+ will continue to be able to access and use Stratus after the SIM Initiative ends. The multi-payer collaborative will also continue to meet, giving payers a forum to advance quality measure and behavioral health integration alignment. However, practice facilitation, and CHITAs will end with the SIM Initiative.

A.2.4 Population health

Key Results
<ul style="list-style-type: none"> • The regional health connector program successfully created clinical-community linkages. • LPHAs and BHTCs continued to convene diverse community partners to improve community awareness of behavioral health concerns and community response to mental health crises. • Post-SIM Initiative sustainability is a potential challenge.

Colorado’s SIM Initiative is starting to positively impact community awareness of behavioral health issues and stigma reduction, connecting providers with community resources and increasing behavioral health screening and referrals (*Table A-9*). Although several state officials and providers said they did not expect significant changes in population-based mental health outcomes measures at this stage in the SIM Initiative, the belief was almost uniform that the population health strategies were generating successes. Stakeholders were hopeful that those successes would translate into improved population health.

Table A-9. Colorado’s progress on population health

Activity	Target population	Key activities	Progress between May 1, 2017, and March 31, 2018
Regional health connector program	Community at large to which they are assigned; SIM-participating practices and CMHCs	Connecting SIM-participating practices and other primary care practices to community resources that improve patient health and helping practices prepare for new models of care and develop projects to advance community health	<ul style="list-style-type: none"> • Each regional health connector (RHC) developed three priority projects to improve healthy eating, active living, mental health and wellbeing, and access to care. Also, each RHC focused one project on cardiovascular health. • Identified and began connecting with new partners able to help further population health goals. • Connected local providers. • Worked with LPHA grantees to help expand LPHA strategies to neighboring counties. • Succeeded in having regional health connectors meet with all Cohort 1 and most Cohort 2 practices to assist with practice transformation.
LPHAs	Dependent on local priority	Implementing projects to address stigma reduction, access to and coordination of BH care, and screening, prevention, and education	<ul style="list-style-type: none"> • Continued project activities.

(continued)

Table A-9. Colorado’s progress on population health (continued)

Activity	Target population	Key activities	Progress between May 1, 2017, and March 31, 2018
BHTC	Aurora and Northern Larimer County public school students and their families	Outreach and education, stigma-reduction campaigns, community-based training and resources, and coordinated systems for mental health screening and referral to mental health services	<ul style="list-style-type: none"> Continued project activities, including coordinating screening and service referral for more than 3,000 individuals by third quarter 2017.¹⁰
Statewide call to action	Male (boys and men) Colorado residents	Creation of recommendations to improve statewide efforts to promote mental health and prevent substance use among males	<ul style="list-style-type: none"> Developed a call to action for release in spring 2018.

BH = behavioral health; BHTC = behavioral health transformation collaborative; CMHC = community mental health center; LPHA = local public health agency; SIM = State Innovation Model.

Regional health connectors

The regional health connector program started to create clinical-community linkages.

Regional health connector projects ranged widely from finding funds to bring medical professionals to underserved geographic areas to building local coalitions to address opioid misuse. Regional health connectors also facilitated partnerships between

“It’s a simple thing she did, but without the regional health connector position, I don’t know if it would have ever happened. It hadn’t happened in 20 years even though [the providers] were kind of co-located.”
—State official

providers and community organizations. Some have facilitated partnerships and connections to community resources by creating mailing lists and monthly newsletters or organizing community resource meetings. Although some providers expressed little awareness of the regional health connector role and reported minimal contact with regional health connectors, other PCPs, PTOs, and CMHCs described achieving successful outcomes by working with their assigned regional health connector. In one example, a PCP reached out to his local regional health connector for assistance in finding a behavioral health partner. In this case, the regional health connector was able to find a behavioral health provider already working in the same office building as the PCP.

Local public health agencies and behavioral health transformation collaboratives

LPHAs and BHTCs continued to convene diverse community partners to improve community awareness of behavioral health concerns and community response to mental health crises. For example, the San Juan Basin Health Department engaged with SIM practices,

¹⁰ TriWest. (2017, October 27). *Colorado State Innovation Model Evaluation: Quarterly Report, April–June 2017*. Retrieved from <https://drive.google.com/file/d/1Yf7H05qXARhU7wE1tlzBV2nu7J0EQ9Xk/view>

behavioral health providers, mental health organizations, public health professionals, schools, youth-serving organizations, and community members to develop local strategies for youth suicide prevention, including the creation of a community-wide response plan to address suicide events and attempted suicide. Between May and October 2017, the CDPHE, a SIM partner, reported an estimated 12 million statewide impressions from anti-stigma campaigns and individuals reached through LPHA education and outreach efforts.¹¹ Impressions measure the number of individuals potentially exposed to LPHA activities through metrics such as Web site hits, attendance at community meetings, and billboard sightings. According to state officials, the vast majority of these impressions can be attributed to the launch of the Let's Talk campaign in the Denver Metro area.¹² Stakeholders expect wider reach across the state as other counties roll out the Let's Talk campaign.

Sustainability

Because the role and value of the regional health connectors are not well understood, state officials were concerned about the sustainability of regional health connectors after the SIM Initiative ends. Regional health connectors wanted the flexibility to do whatever activities were necessary to address community-identified problems. However, the lack of prescribed activities made it challenging for regional health connectors to effectively communicate the nature of their work to clinical providers within SIM-participating practices, the broader community, and payers. Some state officials and providers believed the best way to sustain the program would be through federal and private grants, but others would prefer to see private and public payers fund this workforce directly. The Colorado Health Institute, the SIM Office's partner in this work, has established a work group to make recommendations for sustaining the workforce after the SIM Initiative ends.

Several stakeholders questioned how LPHA and BHTC activities will be sustained after the SIM Initiative ends. Population-based activities do not lend themselves to public and commercial payer support if the activities cannot show immediate cost-savings. The Population Health Work Group, however, has begun discussing how to sustain SIM-related population health activities past the end of SIM funding.

A.3 Implications of Findings/Lessons Learned

The SIM Initiative achieved three major milestones during the AR3 analysis period:

- Cohort 2 primary care practices (154 practices) began participating in the SIM Initiative, and Cohort 1 primary care practices reported success stories in transforming their practices to support behavioral health integration and VBP.

¹¹ TriWest. (2018, February 16). *Colorado State Innovation Model Evaluation: Quarterly Report, July-September 2017*.

¹² The Let's Talk campaign aims to raise awareness of mental health concerns.

- Regional health connectors conducted community needs assessments and began activities to connect clinical, social, and public health resources.
- Planning began on one of Colorado’s SIM-funded health IT investments—the eCQM reporting tool to automate eCQM reporting from providers’ EHRs to a central data warehouse.

Colorado’s SIM implementation experience yielded a range of opportunities and remaining challenges that contribute to lessons learned for other states:

- SIM-participating primary care practices credited support from PFs and CHITAs with helping them prepare for VBP and behavioral health integration.
- Providers appreciated Colorado’s efforts to align SIM quality measures with CPC+ and the MACRA because alignment reduced the reporting burden and signaled where providers should focus their quality improvement efforts.
- Even with TA, providers struggled with reporting CQMs to the state and/or payers.
- Substantive area work groups with clearly defined scopes of work and tasks enabled Colorado to leverage the expertise of subject matter experts to help design SIM activities.
- Providers viewed multi-payer participation in the SIM Initiative as payer willingness to financially support behavioral health integration and practice transformation. However, the lack of a single SIM VBP arrangement frustrated providers. Without more standardization across payers on VBP, long-term, sustainable provider uptake of VBP arrangements is questionable.
- Convening payers and providers to discuss mutual expectations for participation in the SIM Initiative generated mixed feedback.
- Providers had relatively little awareness of the regional health connector role. The sustainability of this role is questionable because state officials did not yet know how to show the regional health connectors’ ROI to a potential funder, such as a commercial payer or health system.
- Implementing health IT and data analytics tools (e.g., Colorado’s eCQM solution, the Stratus data aggregation tool) took more time and effort than anticipated.
- Sharing clinical data across primary care and behavioral health providers proved a challenging yet critical step in integrating physical and behavioral health care.
- Behavioral health provider workforce shortages continued to be a critical barrier to the long-run sustainability of physical and behavioral health care integration.

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Appendix B: State Innovation Model in Model Test States: Connecticut

Key Results from Connecticut's State Innovation Model Initiative May 2017–March 2018

Strategies, progress, and accomplishments, May 2017–March 2018

- The SIM Initiative completed Person Centered Medical Home Plus (PCMH+) Wave 1 and retained all participants for Wave 2.
- State budget cuts and a higher than expected number of new PCMH+ Wave 2 applicants delayed implementation to May 1, 2018.
- The value-based insurance design (VBID) enrolled 11 employers in technical assistance (TA).
- The Community and Clinical Integration Program (CCIP) began working with three participating entities (PEs) on practice transformation.
- The health information technology officer (HITO) made advancements in health information technology (health IT) strategies, although progress remained behind schedule.
- The Advanced Medical Home (AMH) initiative was discontinued and resources moved to the CCIP.
- Community-based organizations (CBOs) were connected with practices to promote shared savings benefits for both the practice and the community.

Stakeholder response to implemented strategies

- Community health workers (CHWs) were seen as valuable in assisting practices with medically complex patients.
- Despite positive changes, health IT was still seen as the area in greatest need of improvement.
- Stakeholders were pleased with the quality measure set and support alignment.

Remaining challenges

- The state continued to struggle to avoid creating redundancies with existing health IT systems.
- Practices needed more support integrating CHWs into workflows.
- Although the relationship improved between the SIM Project Management Office (PMO) and the Department of Social Services (DSS), building a strong collaborative relationship remained a challenge.
- Lack of commercial payer involvement persisted, especially for quality measure alignment.

Sustainability after the SIM award

- The newly created Office of Health Strategy (OHS) provided a comprehensive strategy for continuing to pursue Connecticut's long-term health reform goals.
- Extensive stakeholder engagement is a key strategy to sustain SIM activities.

Connecticut's SIM Initiative, which began on February 1, 2015, aimed to improve population health and health care outcomes and reduce costs. To accomplish these goals, the state focused its SIM Initiative efforts on payment and care delivery reform for the Medicaid population.¹

This updated overview of the Connecticut SIM Initiative is based on an analysis of data collected from site visits, stakeholder telephone interviews, state document reviews, and state program and evaluation calls between May 1, 2017, and March 31, 2018, the Annual Report (AR3) analysis period.² Further details on the analytic approach are available in *Chapter 1*. Information on number and types of stakeholders interviewed for the state is in *Table 1-1*. *Figure B-1* depicts the timeline of major Connecticut SIM and SIM-related activities to date.

B.1 Key State Context and Progress Prior to May 2017

B.1.1 Pre-State Innovation Model health care in Connecticut

Three unique features of the state impact Connecticut's population health and health care environment: (1) the state has good population health overall but significant health disparities, (2) formerly commercially run Medicaid managed care was eventually ended because of questionable cost-effectiveness and moderate performance,³ and (3) as a Medicaid expansion state, the number of Medicaid beneficiaries in the state recently increased.

Prior to the SIM award, Connecticut discontinued Medicaid managed care from private insurers in 2012 and reverted to a state-controlled Administrative Service Organization (ASO) model that was technically fully fee for service (FFS).

B.1.2 State Innovation Model Initiative progress and changes prior to the Annual Report 3 analysis period

Connecticut's primary goals for its SIM Initiative were 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.

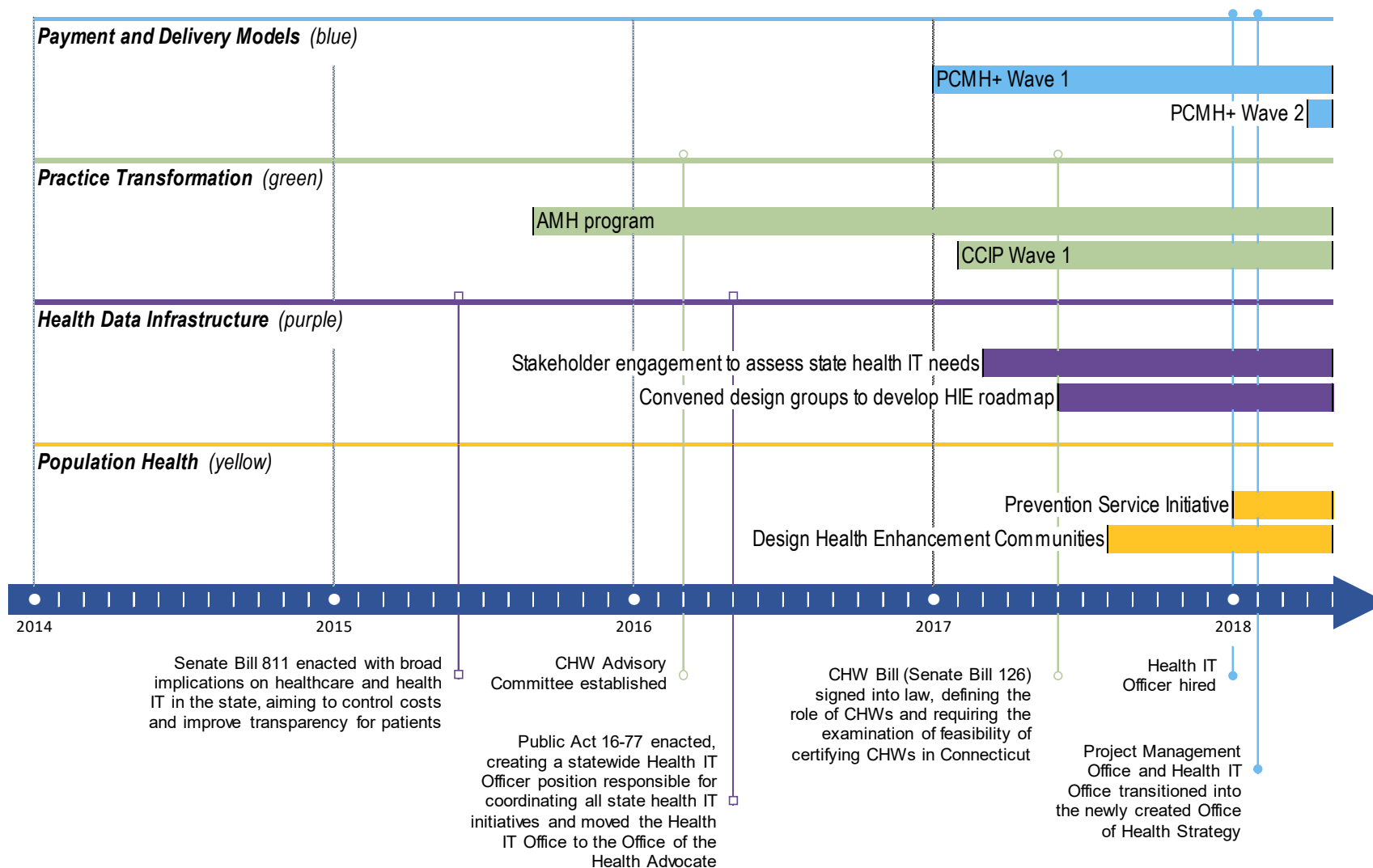
¹SIM Program Management Office (2018). *CT SIM Initiatives*. Retrieved June 18, 2018, from <https://www.healthreform.ct.gov/ohri/cwp/view.asp?a=2741&q=335958>

² Because of scheduling constraints, three interviews occurred outside the AR3 analysis period. Lack of provider participation forced the cancellation of a focus group for non-PCMH+ providers.

³ For more information about the change to an ASO model, see https://www.cga.ct.gov/med/council/2012/0113/20120113ATTACH_DSS%20Presentation.pdf

Figure B-1. Timeline of Connecticut State Innovation Model and State Innovation Model-related activities

B-3



AMH = Advanced Medical Home; CCIP = Community and Clinical Integration Program; CHW = community health worker; health IT = health information technology; HIE = health information exchange; PCMH+ = Person Centered Medical Home Plus.

The SIM Initiative funded the design and launch of the state’s first Medicaid shared savings program (SSP), PCMH+,⁴ which rewarded health care providers that built on patient-centered medical home (PCMH) standards by implementing enhanced care coordination activities and creating linkages with CBOs to address the social determinants of health needs to improve outcomes and improve cost trends. Wave 1 of PCMH+ began January 1, 2017, with a cohort of 127,000 beneficiaries and consisted of upside-only, shared-savings arrangements with nine PEs: seven Federally Qualified Health Centers (FQHCs) and two Advanced Networks (ANs). The state fell short of its initial target to reach 200,000 Medicaid members in its first year of enrollment. Wave 2 of PCMH+ was scheduled to begin on April 1, 2018, and the state hoped to reach between 230,000 and 250,000 attributed lives after the inclusion of the Wave 2 PEs.⁵ Connecticut’s history of commercially run Medicaid managed care generated trepidation around the SSP transformation from a small but vocal group of consumer advocates who feared underservice and a lack of transparency.

The AMH initiative, also launched on January 1, 2017, was designed to provide TA to the practices to help them transform into National Committee for Quality Assurance (NCQA)-recognized PCMHs. Despite significant recruitment efforts, however, the state did not meet its enrollment goal of 150 practices.

In January 2017, the lieutenant governor hired a HITO, a position authorized by the legislature, to oversee health IT activities in the state. The Health IT Advisory Council (Health IT Council) provided policy recommendations, developed priorities, and imparted governance, oversight, and accountability measures to ensure success in achieving the state’s health IT and health information exchange (HIE) goals.⁶

The CCIP launched in March 2017 to integrate nonclinical community services with traditional clinical care. Transformation funds were awarded to three Wave 1 PEs, with TA provided by the vendor Qualidigm to assist in meeting three CCIP standards: (1) comprehensive care management, (2) health equity improvement, and (3) behavioral health integration.

Connecticut promoted VBID as a key SIM strategy to engage consumers. Prior to the AR3 analysis period, the state began working with a consultant to improve employer engagement and decided to provide targeted TA on implementing VBID to self-funded employers.

⁴ Connecticut uses “person centered medical home” in place of “patient-centered medical home.” There are no significant differences in the meaning, and readers can consider the two to be interchangeable.

⁵ Connecticut’s original goal was for PCMH+ to include 400,000 Medicaid beneficiaries by the end of the second wave of enrollment.

⁶ Connecticut State Innovation Model. (2018). *Connecticut SIM Operational Plan Award Year 3 Update, February 1, 2018*. Retrieved from https://www.healthreform.ct.gov/ohri/lib/ohri/sim/test_grant_documents/sim_operational_plan_av3_narrative_1-22-18_revisedfinal_submitted.pdf

SIM-funded projects were coordinated with other major initiatives ongoing in the state, including the Medicare SSP, the ASO’s Intensive Care Management initiatives, and the CMMI-funded Practice Transformation Network initiative. The SIM Initiative made quality measure alignment across initiatives and payers a central component. In November 2016, the Quality Council released the core quality measure set designed for use by commercial and Medicaid payers in value-based payment (VBP) arrangements.

B.2 Progress and Accomplishments from Connecticut’s State Innovation Models Initiative, May 2017–March 2018

B.2.1 Delivery models and payment reforms

Key Results
<ul style="list-style-type: none"> • PCMH+ Wave 1 completed a full year, and Wave 2 applications were accepted. • Increased provider focus on quality of care and positive PE collaboration were seen as major PCMH+ accomplishments. • Lack of timely PCMH+ performance data and Medicaid attrition were seen as challenges. • Some consumer advocates voiced concerns about PCMH+ incentivizing providers to underserve Medicaid beneficiaries. • Eleven employers received VBID TA.

Connecticut made significant progress on its key delivery system and payment reform initiative, PCMH+, by completing Wave 1 and beginning the application and negotiation process for Wave 2 PEs (*Table B-1*). Providers increased their focus on quality performance and patient experience, as they began to recognize their accountability for a cohort of people. New relationships were forged, as the PEs collaborated during peer-to-peer learning activities. However, PEs reported that because they have not yet received any utilization and expenditure data for their attributed lives, they did not know whether their efforts were successful. A decline in the number of Medicaid beneficiaries attributed to the PEs was a major challenge that subsequently reduced advanced payments for participating FQHCs. Some consumer advocates continued to voice concerns about PCMH+ incentivizing providers to underserve sicker Medicaid beneficiaries to reduce expenses and generate more savings. VBID enrolled 11 employers for targeted TA.

Table B-1. Connecticut’s progress on delivery system and payment reforms

Activity	Target population	Key activities	Progress between May 1, 2017, and March 31, 2018
PCMH+ initiative	Medicaid beneficiaries	Providing enhanced care coordination; promoting payment models that improve quality and lower cost of care	<ul style="list-style-type: none"> Wave 1 of PCMH+ was completed, and recruitment of practices for the second wave began in January 2018.
VBID	State employees	Providing TA to employers to promote value-based health benefits	<ul style="list-style-type: none"> The state worked with a consultant to engage employers in VBID; 11 employers were selected to receive implementation TA.

PCMH+ = Person Centered Medical Home Plus; TA = technical assistance; VBID = value-based insurance design.

Person Centered Medical Home Plus initiative

PCMH+ Wave 2 was originally scheduled to launch on January 1, 2018; however, because of state budget cuts, the launch was delayed by three months to begin on April 1, 2018. As of March 31, 2018, the state’s Medicaid program had received nine applications for the second PCMH+ wave, but no new PEs had yet been selected. State officials attributed the selection delay to an unanticipatedly high number of applicants, which caused the contracting office’s negotiating process to take longer than anticipated.

PCMH+ successfully retained all Wave 1 PEs. State officials explained that the focus of Wave 1 was to work with the PEs to integrate their current resources with new resources and develop programs that fit both their patient populations and PCMH+ goals. Wave 1 PEs were scheduled to re-enroll and join the new Wave 2 PEs for a new 2-year period of performance, expanding and continuing lessons learned from Wave 1.

Several interviewees mentioned an increased focus on quality measures among providers as the greatest accomplishment of PCMH+. One state official reported that providers started looking critically at the quality of care they provided and the quality of the patient experience. Another state official explained that the PEs began recognizing their accountability for a whole cohort of people and the need for “engagement, connections, and person-centeredness.” One provider explained that PCMH+ gave them the impetus to build out a much larger quality dashboard and to organize a team to focus on building more of a population health focus into their measures.

State officials also noticed more positive engagement among the PEs. Prior to PCMH+, stakeholders noted that the delivery system atmosphere did not cultivate collaborative behavior. In the AR3 analysis period, the PEs participated in peer-to-peer learning through DSS-hosted meetings every other month. The PEs shared best practices with one another, discussed

challenges, and talked through solutions. The DSS also provided TA at these meetings, as needed.

Despite the PCMH+ accomplishments noted by stakeholders, a small number of consumer advocates continued to express concerns about PCMH+ incentivizing participating providers to underserve more expensive, sicker patients to maximize their savings. One consumer advocate explained, “The problem is proponents of the model insist it will be done the right way by better coordinating care and providing preventive care and preventing more expensive complications down the road, but they are generally unwilling to accept the fact that providers could save money in lots of ways that are not good.” Multiple interviewees noted that opposition from consumer advocates delayed the implementation of both Wave 1 and Wave 2.

State officials addressed concerns regarding potential underservice and discriminatory practices by implementing a multipronged strategy to ensure providers were not discriminating against patients. The state strategy included reviewing quality

“Moving [PCMH+] forward in a way that maintained fidelity to our values as a Medicaid program was a key at each turn in terms of model design and programmatic oversight of ensuring that those payment strategies did not incent behaviors that worked against Medicaid members’ interests but instead furthered them.”

—State official

measures, conducting a consumer experience survey (Consumer Assessment of Healthcare Providers and Systems [CAHPS]), and examining grievance data. State officials noted they had been transparent in sharing all available data (e.g., consumer experience survey data, mystery shopper data, grievance data). State officials reported seeing nothing to indicate any ill effects for members based on these data but rather positive changes toward more coordination and more attention to person-centeredness. Despite these actions, the negative incentive issue remained a point of contention for some advocates.

One of the most widespread criticisms of PCMH+ from various stakeholders was the lack of timely data.

Several PEs noted that it would be 18 months after PCMH+ Wave 1 began before they received the first data indicating whether their efforts had successfully reduced expenditures and improved outcomes. This time encompasses the period of performance and the necessary run-out period to ensure claim completion.⁷ According to one provider, “We have done a ton of work and we have no idea where we stand. The doctors are really unhappy because they have no idea how they’re doing.” In contrast, another provider commented that not having

“We’re focusing a lot of energy on hitting the value metrics and we’re doing that as a gateway to open up shared savings, but we don’t even know what we should be doing in shared savings to save.”

—Provider

⁷ **Run-out period** refers to the period after the date of service during which a claim may be submitted for payment. In Medicaid claims analysis, it is common to include a 6-month run-out period before analyzing a claim to ensure that no additional claims, modifications, or reversals are submitted for the encounter.

potential savings data did not affect service provision at their practice because providers are “driven to quality” regardless of data.

Additionally, several stakeholders noted that implementing Wave 2 before seeing quantitative data from Wave 1 was potentially shortsighted because it did not allow for valuable course correction before expansion. State officials held the opposing view: that postponing Wave 2 would lose valuable momentum and, as a result, fail to capitalize on the early investments and

“It’s hard to make changes looking in a rear-view mirror.”
—State official

lessons learned from Wave 1. Wave 2 is scheduled to last for 2 years. At the time of the most recent site visit, it was unclear if Wave 2 PEs would receive interim reports on attributed lives during the 2 years or only after the end of the period of performance.

One major operational challenge during Wave 1 was significant Medicaid eligibility attrition. PCMH+ was initially designed so that any beneficiary who lost their Medicaid eligibility for even 1 day during the year was dropped from the PCMH+ program, with no mechanism for reinstatement. This design led to significant declines in the number of attributed lives for the PEs and subsequently reduced advanced payments for participating FQHCs. One provider described their attribution list as going from 45,000 Medicaid beneficiaries in January 2017, the first month of PCMH+, to 29,000 Medicaid beneficiaries as of March 2018: “Had we based staffing models on that original number, we would have been in big trouble, but we didn’t.” Another provider reported that their practice’s attribution number had dropped approximately 30 percent from the original number over the course of a year. State officials noted that this challenge was further exacerbated by the DSS’s simultaneous replacement of its eligibility management system, which caused additional administrative challenges.

Eligibility experts at the DSS posited that this type of eligibility attrition was not historically atypical and, further, that the rate at which beneficiaries in PCMH+ lost their eligibility was no different than the rate for the general Medicaid population. To mitigate the eligibility attrition issue, the DSS provided all PEs the dates of eligibility redetermination for their attributed lives so that the PEs could contact members in advance to avoid potential coverage lapses. These challenges and lessons learned led the SIM Initiative to redesign PCMH+ Wave 2 so that anyone who lost their eligibility status but was reinstated within a 120-day period would not be removed from the PCMH+ program.

A related issue that representatives from PEs raised was that the reported quality metrics were based on the PE’s entire Medicaid patient population, regardless of whether a beneficiary was participating in PCMH+. This meant that PEs were held accountable for quality metric improvements for all Medicaid patients, regardless of whether they received advanced payments or potential shared savings. Therefore, the tools that the state intended to offset the burden of practice transformation and care delivery reform (advanced payments and shared savings) were only available to a proportion of those beneficiaries that would be included in measuring the

program's successes. Representatives from several PEs reported that when the state was asked to measure quality metrics only for those beneficiaries attributed to PCMH+, state officials indicated they did not have the capability to separate the populations. One stakeholder described this data limitation as "unacceptable in a shared value program."

A variety of opinions surfaced on the benefits and drawbacks of the prescriptive nature of PCMH+. Several providers said PCMH+ was too prescriptive and not focused on the most efficacious features, given the short measurement time period and limited resources. However, one provider held a contrary view—that the prescriptive nature of the program was a benefit because their practice would not have implemented certain changes on their own without the impetus for change driven by PCMH+. The same provider gave the example of the requirements for additional screenings and transitions management, saying that this requirement likely produced changes in practice that would have otherwise been ignored. Some stakeholders described PCMH+ as lacking established clear guidance and practice expectations regarding behavioral health integration. The PEs were required to have a process in place to address behavioral health within their patient population, but PCMH+ neither defined a targeted population nor required a particular set of services to be offered.

One provider expressed concerns that the Wave 1 period of performance was too short to truly impact cost savings, commenting, "I tell people, if there were shared savings for some reason and we spend less money in the second year and we can share them, that's great. But I don't think it's because of anything I've done in that short period of time that impacted cost savings." Another provider said the shared savings were "too incremental and too small" to force or even encourage providers to make substantive changes that would truly transform practices.

Value-based insurance design

In January 2018, the PMO launched a request for proposals (RFP) for self-funded employers interested in receiving TA on VBID. The VBID Consortium participated in and co-hosted numerous employer engagement events, meetings, and Webinars to promote the VBID TA RFP among business and human resources groups, including the CT Business Group, Northeast Business Group on Health, Connecticut Association of Health Underwriters Benefit Brokers Benefair, Society for Human Resource Management State Council, Human Resources Association of Central CT, Business Council of Fairfield County, and Human Resources Leadership Association of Eastern CT. Eleven employers were chosen to be the first wave to receive TA from Freedman HealthCare through the SIM Initiative, which began in April 2018. The state plans to provide TA for up to 20 additional self-insured employers across two cohorts in Award Years 3 and 4, with several stakeholders expressing satisfaction with the program's progress.

The VBID Consortium updated its recommended VBID benefit plans templates for fully- and self-insured-employers, highlighting the benefits of VBID components. One payer highlighted this as a main accomplishment of the SIM Initiative in the AR3 analysis period. To support the VBID strategy, the PMO, in collaboration with the University of Connecticut (UConn) state evaluation team, developed a survey to assess the number of beneficiaries enrolled in VBID plans. However, the PMO and the UConn evaluation team both reported difficulty obtaining survey results from all payers because of slow responses from health plans.

“There’s been good engagement on VBID in the last year. I’d like to see more of that.”

—State official

B.2.2 Progress toward a preponderance of care in value-based payment and alternative payment models

Key Results
<ul style="list-style-type: none"> • Stakeholders expressed doubt that Connecticut was on track to meet the 80 percent preponderance of care goal by the end of the SIM award. • Baseline data showed that Connecticut made some progress toward their preponderance of care, particularly in Medicare, prior to SIM Initiative implementation. • Medicaid beneficiaries who were attributed to PCMH+ but lost Medicaid eligibility at any point during the performance period were dropped from the program indefinitely, resulting in a decline in attributed lives and subsequent advanced payments (at FQHCs) throughout the year • The Primary Care Modernization plan was introduced to create a multi-payer primary care payment reform model that enables primary care providers (PCPs) to expand and diversify their care teams and provide more flexible, non-visit based methods for patient care, support, and engagement.

Stakeholders expressed doubt that Connecticut was on track to move 80 percent of its population, providers, or health care expenditures into a VBP or primary care delivery model by the end of the SIM award period. Challenges the state encountered included delayed PCMH+ implementation and limited commercial payer engagement. The participation of PCMH+ practices in Wave 2 should enable the state to make some progress toward the preponderance of care goal. Even so, the state expected the PCMH+ program to fall short of the goal, capturing only 25–33 percent of all Medicaid beneficiaries in VBP or alternative payment models (APMs) arrangement by the end of the SIM test period. However, some stakeholders estimated that they had already reached 80 percent of PCPs.

Table B-2 presents the extent to which Connecticut’s population is participating in SIM payment and health care delivery models, as provided by the state in its Award Year 2, Report 5 to CMMI.⁸ According to the metrics submitted, the number of Medicaid beneficiaries attributed to an APM in

“The problem with attribution models is that they don’t capture people who don’t go to visits every year. There’s a lot of people going to MinuteClinics or urgent care and won’t be on the attribution radar. So even if you have 100 percent of commercial contracts in accountable care, you’re not going to get all the lives attributed unless you introduce an auto-assignment technology.”

—State official

Connecticut was 109,356 (16.7 percent) in Award Year 2, a decrease from 127,000 in Award Year 1. As detailed in **Section B.2.1**, beneficiaries who lost Medicaid eligibility at any time were no longer counted as attributed lives in the model, and this decrease is likely a reflection of that attrition. A state official also explained that the use of MinuteClinics and urgent care facilities could be a factor contributing to inaccurate beneficiary attribution counts. For these reasons, state officials and providers viewed reaching the preponderance of care goal as a greater challenge for reaching 80 percent of beneficiaries than reaching 80 percent of providers.

Table B-2. Population reached by a value-based payment or alternative payment model in Connecticut, latest reported figures as of Award Year 2, Annual Report

Payer type	SIM models			Landscape
	ACOs	Other ¹	SIM Initiative-wide	Any VBP or APMs
Medicaid	109,356 (16.7%)		109,356 (16.7%)	—
Commercial		221,468 (8.7%)	221,468 (8.7%)	—

Source: Connecticut SIM Initiative Award Year 2, Report 5 Metric Template.

— = relevant data not provided in the data source; ACO = accountable care organization; APM = alternative payment model; SIM = State Innovation Model; VBP = value-based payment.

¹ “Other” represents the number of commercially covered lives with a VBID insurance plan.

Note: Denominators are provided by United State Census American Community Survey 5-Year Estimates (<https://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml>; accessed on May 31, 2018).

Table B-3 presents the extent to which Connecticut’s payers were participating in a VBP or APM as defined by the Learning and Action Network categories, as of Award Year 1, which represents baseline data. In that year, almost one third (32 percent) of Medicaid and over half of Medicare (56 percent) payments were in VBP or APMs (Categories 2–4). Of the five commercial payers that replied to the APM survey, 46 percent of their payments were in VBP or APMs. In Connecticut, a number of providers were engaged in the Medicare SSP starting in 2013. A number of commercial payers in the state also adopted VBP models prior to the SIM Initiative.

⁸ Because these data were not verified by CMMI, the RTI team cannot attest to their accuracy.

Table B-3. Payers participating in a value-based payment or alternative payment model in Connecticut, Award Year 1

Payer	Category 1 Payment: FFS with no link of payment to quality		Category 2 Payment: Payment linked to quality		Category 3 Payment: APMs		Category 4 Payment: Population-based payment	
	Number of beneficiaries	Percentage of payments	Number of beneficiaries	Percentage of Payments	Number of beneficiaries	Percentage of payments	Number of beneficiaries	Percentage of payments
Medicaid	651,546	68%	174,298	20%	127,101	12%	0	0%
Medicare	267,823	44%	22,761	2%	503,514	54%	0	0%
Commercial	2,267,992	54%	14,991	10%	1,747,868	36%	0	0%

Source: Connecticut SIM Initiative Award Year 2, Report 5 Metric Template.

APM = alternative payment model; FFS = fee for service; SIM = State Innovation Model.

Table B-4 presents the extent to which Connecticut’s providers were participating in VBP or APMs. As of Award Year 2, Connecticut reported that 580 providers in FQHCs or ANs were participating in Medicaid PCMH+. ⁹ Metrics for statewide provider participation in any APM or VBP were not available; however, interviewed stakeholders estimated that 85 percent of PCPs in Connecticut were engaged in an APM or VBP.

Table B-4. Providers participating in a value-based payment or alternative payment model in Connecticut, latest reported figures as of Award Year 2, Annual Report

Provider type	SIM models			Landscape
	ACO	Other ¹	SIM Initiative-wide	Any VBP or APMs
Providers	580 (15%)	—	—	—

Source: Connecticut SIM Initiative Award Year 2, Report 5 Metric Template.

— = relevant data not provided in the data source; ACO = accountable care organization; AN = Advanced Network; APM = alternative payment model; FQHC = Federally Qualified Health Center; PCMH+ = Person Centered Medical Home Plus; SIM = State Innovation Model; VBID = value-based insurance design; VBP = value-based payment.

¹ “Other” represents VBID insurance plans.

Note: The denominator for providers (3,786) was obtained from Association of American Medical Colleges State Physician Workforce Data (<https://www.aamc.org/data/workforce/>; accessed on July 3, 2018). The numerator is the number of providers in FQHCs or ANs in PCMH+.

Looking ahead at sustaining the state’s progress toward a preponderance of care in APMs, state officials introduced a plan for primary care payment reform, called Primary Care Modernization. The state’s Practice Transformation Task Force released a report in February 2018 with recommendations to (1) implement payment reforms that invest more resources into

⁹ The number of practices and providers participating in VBP or APMs was not reported for Award Year 1.

PCPs and enable providers to diversify their care teams, (2) provide options for nonvisit-based patient care, and (3) replace some FFS payments with bundled payments. The state released an RFP in March 2018 for a Primary Care Modernization consultant to conduct stakeholder engagement and develop a primary care payment model and associated requirements. State officials believed the next administration’s willingness to spend resources on administering a statewide shared savings plans would be a factor in Connecticut’s ability to reach and maintain the targeted preponderance of care.

B.2.3 Enabling strategies to support health care delivery transformation

Key Results
<ul style="list-style-type: none"> • Readiness and transformation plans were completed for all CCIP PEs. • Practices viewed CHWs as helpful for managing patients with complex medical conditions. • A new law paved the way to a CHW certification process in Connecticut. • Readiness assessments identified the health equity improvement standard as an area of improvement. • Health IT and HIE remained the areas stakeholders thought most needed improvement. • Alignment of commercial payers around the quality measures remained a challenge. • The AMH program was discontinued because of lower than anticipated participation rates.

Stakeholders moved forward with the CCIP, health IT, and quality measurement strategies during the AR3 analysis period. The AMH program was discontinued after lower than anticipated participation rates, and the remaining funds were moved to the CCIP. Challenges remained in public and private sector payer engagement for health IT and quality measurement alignment, and stakeholders expressed concerns about advancing health IT and HIE strategies within a limited timeframe.

Advanced Medical Home initiative

As of March 31, 2018, 125 practices had achieved NCQA PCMH recognition through the AMH initiative, lower than the goal of 150. The state believed that AMH initiative participation was lower than anticipated because of a perceived lack of return on investment (ROI), the burden of maintaining NCQA recognition, and the general uncertainty around health care reform efforts in the state. As a result, the state decided to discontinue the AMH program in summer 2017. All awarded practices were to continue to receive intensive TA from Qualidigm, the TA vendor, until they achieved NCQA recognition or the end of 2018, but new practice waves would not be accepted into the program. The PMO, with input from the Steering Committee, decided in 2017 to reallocate AMH-designated funds to the CCIP, for practice transformation, for the CHW ROI analysis, and to bolster population health planning efforts.

Community and Clinical Integration Program

Each of the CCIP Wave 1 PEs¹⁰ received a Qualidigm readiness assessment and transformation plan in July 2017. These assessments established a baseline for each PE on the three core CCIP standards (*Table B-5*) that informed the development of the transformation plans. The PEs hired CHWs using the transformation funds awarded by the PMO to help achieve the comprehensive care management and health equity standards. The PEs were successful with the screening and referral components of the behavioral health integration standard, but the tracking component remained a challenge.

Table B-5. Connecticut’s progress on enabling strategies to support health care delivery transformation

Activity	Target population	Key activities	Progress between May 1, 2017, and March 31, 2018
AMH initiative	Medicaid beneficiaries	Supporting practices participating in PCMH+ to become medical homes to integrate high-quality care	<ul style="list-style-type: none"> Because of lower than anticipated participation, AMH was discontinued, but practices were to continue to receive TA until they became NCQA-recognized medical homes.
CCIP	Medicaid PCMH+ Providers	Integrating nonclinical community services with traditional clinical care following three standards: comprehensive care management, health equity improvement, and BH integration	<ul style="list-style-type: none"> Qualidigm completed transformation plans and readiness assessments for the PEs. PEs hired CHWs to manage patients with complex conditions. PEs worked to determine ROI from CHW utilization.
Health IT	Medicaid PCMH+ providers	Establishing health IT infrastructure and a statewide HIE system	<ul style="list-style-type: none"> Conducted extensive stakeholder outreach, including an environmental scan, stakeholder forums, and community roundtables. Worked to integrate Medicaid data into the APCD.
Quality measure alignment	Medicaid PCMH+ providers	Implementing quality measure alignment following the core quality measure set	<ul style="list-style-type: none"> Completed 60% alignment of core measures in VBP models across health plans.

AMH = Advanced Medical Home; APCD = all-payer claims database; BH = behavioral health; CCIP = Community and Clinical Integration Program; CHW = community health worker; health IT = health information technology; HIE = health information exchange; NCQA = National Committee for Quality Assurance; PCMH+ = Person Centered Medical Home Plus; PE = participating entity; TA = technical assistance; ROI = return on investment; VBP = value-based payment.

¹⁰ Two ANs and one FQHC, both of which participate in PCMH+.

CHWs were generally successfully in helping practices manage patients with complex medical conditions. One PE explained that they assigned patients to the CHWs if they had diagnoses such as obesity, hypertension, diabetes, asthma, and depression. Each PE hired two to four CHWs, depending on funding and need, with caseloads averaging 30–100 patients per CHW. Provider interviewees were receptive to and enthusiastic about the integration of CHWs into their care teams.

“The CHWs are so successful with the patients they’ve intervened with. We have good evidence that they’ve decreased ER [emergency room] visits and decreased admissions. It’s been really great but there aren’t enough CHWs.”

—Provider

The PMO noted that some PEs required assistance integrating the CHWs into their workflow. To respond to this need, Qualidigm developed two educational modules: “Understanding the Community Health Worker Role” and “Paving the Way for Successful CHW Integration.” Additionally, a CHW Web site was launched in August 2017 to serve as the central platform for all CHW-related activities and provide the PEs with ongoing educational information and guidance.

Demonstrating the ROI from CHW utilization was a challenge reported by both the state and PEs. Because of the multiple factors and competing processes taking place, stakeholders agreed it was difficult to isolate a ROI based on only the work of a CHW in a complex care delivery system. Because the PEs were required to calculate the ROI to justify funding the CHWs, the SIM PMO contracted with the University of Pennsylvania CHW Center to conduct ROI analyses. Two of the PEs also relied on the University of Pennsylvania for guidance on effectively using and integrating the CHWs, which they found very helpful.

The CHW Advisory Committee, which was formed to support the needs of the CCIP PEs, organized a 1-day in-person interactive workshop for approximately 30 CHW supervisors from both the PCMH+ and CCIP PEs. The workshop focused on defining the CHW’s role within the care team, educating the care team on the CHW’s role, and supporting the unique needs of the CHW.¹¹ The state reported positive feedback on the workshop.

In June 2017, a new law was enacted with the goal of creating a CHW certification process. The law defined CHWs in Connecticut and required the PMO to work with the CHW Advisory Committee and the Department of Public Health (DPH) to study the feasibility of creating a CHW Certification Program.¹² A report on the study findings and recommendations are due to the General Assembly by October 1, 2018. Many interviewees noted the challenge of

¹¹ Connecticut SIM Quarterly Progress Report 3 to CMMI, 2017.

¹² Senate Bill 126, An Act Concerning Community Health Workers, signed into law as Public Act 17-74

hiring CHWs with behavioral health expertise and/or other credentials and experience to meet the needs of the PEs' members. Providers generally supported licensing for CHWs.

The readiness assessments identified the health equity improvement standard as the area in which the PEs most needed assistance. A kick-off event in October 2017 enabled the PEs to talk about health equity and discuss the steps needed to achieve the standard. The initial implementation phase focused on improving the collection of race and ethnicity data. Collecting these data requires specific electronic health record (EHR) capabilities and configurations, which often require fees to implement. Additionally, new workflows needed to be developed and staff trained on how to collect this type of sensitive data. Two of the three PEs also participated in the Accountable Health Communities Model (also funded by CMS), which did not require the collection of detailed race and ethnicity data. The PMO appealed to CMS to agree to align the race and ethnicity data requirements for the two initiatives in Connecticut, but no decision had been reached at the time of writing. Supplemental awards were expected to be released in May 2018 to provide additional funding and TA to help resolve the data collection issues that arose among the CCIP PEs during the first wave. Once the data collection issues are resolved, a second implementation phase is planned to identify gaps in care for racial or ethnic groups and establish a CHW-led pilot.

The PEs successfully met the screening and referral components of the behavioral health standard, but the tracking component remained a challenge according to state officials. While the PEs' EHRs could document that a screening took place and that a referral was made, the EHRs were not configured to capture and report whether the patient connected to care or confirm that service was delivered. The SIM PMO recognized this as a major issue for implementing the CCIP as intended and for achieving the behavioral health integration core standard. To help with this issue, state officials hoped the PEs would use the supplemental awards (mentioned above) to reconfigure their EHRs or develop another method to track referrals.

State officials acknowledged hearing complaints from the CCIP PEs about the duplication of requests for reporting measures from PCMH+ and CCIP consultants. The PMO, DSS, and all the consultants involved responded by working together to identify areas around which they could better align work flow, including information sharing, the coordination of in-person meetings, and the development of TA strategies. One PE explained the frustration of trying to get clarity on what they would be held accountable for (for example, not knowing whether that PE would be held accountable for the work provided by the CHW): "It's been this unveiling of progressively more stringent requirements that we need to hit, which I like a challenge, but the challenges are coming out of the blue when the project is supposed to be done in a couple of days."

The TA vendor, Qualidigm, was supported practices in transforming to PCMHs as the AMH vendor but was unable to provide assistance with specific CCIP requirements and standards. For example, because Qualidigm did not possess the technical expertise needed to assist the PEs with the health equity standard, the TA plan it developed for the PEs would not have worked. The PEs were left to find guidance elsewhere, which slowed down the transformation process. In spring 2018, the PMO elected to discontinue the contract with Qualidigm, procuring new TA for the PEs in both the first and second waves of the CCIP.

Health information technology

Almost all stakeholders acknowledged challenges in the areas of health IT and HIE but noted that new leadership did make improvements. Challenges included a historical lack of vision that delayed state progress, communication challenges among agencies and partners, and infrastructure limitations. Stakeholders were also concerned that developing a statewide solution that did not account for existing private sector health IT solutions would create redundancies. Multiple stakeholders noted that the leadership and vision of

“Connecticut is disadvantaged because it hasn’t been able to get its act together for years, but putting that aside, Connecticut is probably in the most advantageous place in the country right now because you can look out across the landscape to see what’s worked, what hasn’t worked, and can go right past it all.... The people working on this ...are all waking up to the possibilities of what’s possible here.”

—State official

the new HITO, who began working on the SIM Initiative on January 1, 2017, along with new statutory authority enacted at the end of the AR2 analysis period, enabled health IT strategies to progress during the AR3 analysis period, which significantly improved the health IT landscape in Connecticut and should allow for greater health care transformation moving forward.

The creation of the HITO position enabled the focus on health IT to gravitate from one agency, DSS, to the newly formed OHS, effective January 1, 2018. Previously the state was challenged in making progress in its health IT initiatives and lacked a central focus. The establishment of this position within OHS enabled the HITO to advance organizing strategies for health care information exchange and analytics. OHS brings together the Chief Health Policy Advisor from the Lieutenant Governor’s office, the SIM PMO, the Health Information Technology Office, the Office of Health Care Access, and the All Payers Claims Database. OHS has access under one agency to three critical cost and quality data components—claims data in the all-payer claims database (APCD), hospital discharge data, and hospital financial data—with the goal of enabling the OHS to bring the relevant data together to drive fact-based policy decision making.

The state recognized the need to avoid reinventing the wheel and expressed commitment to developing health IT and HIE systems to help providers get a return on previously implemented health IT investments. Toward that end, the HITO undertook extensive stakeholder

outreach—including an environmental scan, stakeholder forums, and community roundtables—toward the end of AR2. The results were released in a May 2017 report¹³ to ensure consideration of the investments that hospitals, ACOs, FQHCs, and other providers (e.g., nonprofit visiting nurses, long-term post-acute care services) had already made in their organizations.

To avoid redundancy, Connecticut also planned to pursue a “network of networks” strategy rather than a central warehouse of health data, leaving the data where they had been created and collecting additional data only as necessary. Rather than focusing on

building a new system for data exchange, the SIM Initiative decided to focus on using the data analytics of existing systems to drive policy, research, and programs. The Health IT Council recommended avoiding point solutions that require securing vendors to produce sets of analytics and instead focusing on the Core Data Analytics Solution as a master data management solution. For example, the SIM Initiative focused on electronic clinical quality measures (eCQMs) to have a common set of metrics upon which to build VBIDs, APMs, and quality-based programs.

“SIM is around payment and practice reforms to drive better health outcomes in the state. Nothing gets you there faster than having the facts, and the facts now are coming together in a consolidated fashion. I think this puts SIM in a terrific spot. Data is power. If you have the data and the facts, you’re in the best position to drive reforms because you know where the reforms need to be.”
—State official

“We need to be able to pivot as priorities change, as capabilities come in, capabilities go out, funding comes here, funding goes away, you have to be able to pivot and not be saddled with point solutions. All of this, the network of networks concept and this notion of open analytics as opposed to point solutions, are two of the critical decisions that have been made that are going to drive forward what we’re doing here in Connecticut.”
—State official

The health IT strategy was to collect raw metrics to create eCQMs, rather than collecting all personal health records in one central database. The Core Data Analytics Solution would focus initially on eCQMs but eventually might be used to address race, ethnicity, and language data or the APCD.

Stakeholders noted that health plans were concerned about data security and the market implications of performance comparisons in the context of HIE participation. Providers raised concerns about reimbursement for eConsults, interoperability among EHRs, and the need for access to meaningful data

to operate in an APM environment. Providers expressed frustration about the lack of availability of claims data and quality metrics for their target populations, as they worked towards transforming practices and service delivery. Providers underscored the need for systems that

¹³ Matthews, M., & Robinson, C. (2017, May 23). *Assessing Connecticut’s health information technology & health information exchange services: Summary findings of current state, future needs, and recommendations for action.* Retrieved from https://portal.ct.gov/-/media/OHS/Health-IT-Advisory-Council/Reports/Environmental_Scan_Summary_Findings_FINAL_20170523.pdf?la=en

could accept, receive, analyze, and report data—so they can know how their practice is performing in real time rather than on an annual or often longer, retrospective basis. The SIM plan for data linkages and aggregation of data across multiple locations to a single point for analysis was intended to address these concerns. However, according to one stakeholder, “We don’t really have a standard understanding or universal understanding of how that’s possible and what it would take to do that.”

The DSS was a critical partner in advancing the health IT and HIE strategies, yet stakeholders cited significant delays resulting from DSS processes. One challenge was the delayed incorporation of Medicaid data into the APCD with the existing Medicare and commercial data. Although 2012 legislation required Medicaid to supply data, there were still no data 4½ years later. A statutory change was made in the 2017 session to address any technical issues in the 2012 statute, and the HITO and OHS were working with the DSS to resolve the issue and fully integrate Medicaid data into the APCD.

Another obstacle that hindered health IT progress was getting the DSS to secure the federal funding needed for the HIE. This step is critical to collecting quality metrics from all the state’s EHRs into the HIE and bringing eQMs to scale because the state’s strategy depends on the HIE to gather quality metrics of all EHRs around the state. As one stakeholder noted, “To scale the eQMs, they [the SIM team] need the HIE up and running to be able to connect to as many EHRs as they can to get the volume they need. The advisory councils all agree on how we’re going to do this. We’ve got to get the funding. If we have to do point-to-point connections to keep going with the eQMs, we’ll do that, but it would go a lot faster if we could do the HIE.”

As a separate challenge, DSS delayed the submission to CMS of the Implementation Advanced Planning Document with the inclusion of the DPH Immunization Information System (IIS) as approved by the Health IT Council in December 2017. This document was submitted to the DSS for review and acceptance to submit to CMS in early January 2018. The purpose of this document is to integrate the IIS into the PMO’s implementation of HIE services with CMS Health Information Technology for Economic and Clinical Health (HITECH) funds. The DPH Immunization Program prepared the document with PMO support. At the time of the site visit, the document had not advanced further.

Yet another challenge was the potential duplication and lack of alignment of admission, discharge, and transfer (ADT) notifications. In the absence of an HIE, the Connecticut Hospital Association sponsored a contract with PatientPing, a health technology company, to deliver ADT notifications for hospitals. One FQHC was using PatientPing, but other practices found its cost an unsurmountable burden to its adoption, leading the DSS to disseminate a similar but more affordable product, Project Notify, specifically for FQHCs. The resulting confusion as to how PCPs across practice settings were receiving ADT notifications led to inconsistencies in delivery and state efforts to reconcile the disparate systems.

Quality measure alignment

As of March 2018, the alignment of core measures in VBP models across health plans was about 60 percent (with a 75 percent goal), based on four of six payers reporting in 2017. Additionally, the CAHPS survey had been conducted for both commercially insured and Medicaid populations. One of the survey’s goals was to provide data health plans could use to assess and reward consumer experience performance under shared savings contracts.

Stakeholder feedback was positive on the process of developing quality measures but mixed on its outcome.

Many stakeholders expressed satisfaction with the Quality Council’s process for determining a core quality measures set. One provider noted, “There were a number of good clinicians whose judgement I trust who put that together on the Quality Council.” One consumer advocate expressed support for quality measure alignment based on the belief that (1) Medicaid and its beneficiaries were better protected from marginalization when part of a larger system of reform, and (2) multiplayer quality alignment efforts were one way to prioritize the health of vulnerable populations alongside commercial plan beneficiaries: “I come from the philosophy that a one-tiered system is what works best. Quality for everybody, whether you’re the governor or on Medicaid or in a commercial plan.” Another provider expressed frustration with the measures chosen, questioning whether the right outcomes were being measured.

“The single biggest accomplishment is that it’s expanded the menu of quality indicators that we’re tracking, monitoring, and actively working on. This gave us the impetus to build out a much larger performance dashboard and put together a team to focus on it and build more of a population health focus into our measures. We probably would have done some of that, but this really put some wind behind the sails.”

—Provider

Alignment of commercial payers around the quality measures remained a challenge.

While many stakeholders expressed the need to increase quality measure alignment to improve health quality, harmonize quality initiatives for providers, and reduce reporting burden, one commercial payer noted that getting payers to align on quality measures would be a challenge because, “...it is about what we as payers feel like we need to individually deliver to our customers and how we need to distinguish ourselves.”

“The private payers kind of just walked away [from discussions of quality measure alignment] and said that was an interesting discussion but we don’t see this as applying to us... there’s not the enforcement idea around that or the attachment of those standards, it’s really more of a discussion of philosophy.”

—State official

Reporting and receiving data related to quality measures was a challenge for providers, the SIM leadership team, and the UConn evaluation team. One provider noted that capturing and reporting the selected quality measures was difficult: “Our data system has

been built around capturing from the Healthcare Effectiveness and Data Information Set (HEDIS) metrics. When they [DSS and SIM leadership] say, we want you to measure it this way, we can't because our system isn't built to do that. They're going out of the box and it's problematic." Several providers noted that receiving timely data on quality metrics from the state was also a challenge. One noted, "We're running our own data. If we waited on the state to do anything with data, by the time we get that data it's not really relevant." SIM leadership noted that quality metrics were integral to measuring the effects of PCMH+ and the CCIP among PEs and that proceeding with new waves of PEs without feedback was difficult. Finally, the UConn team prepared to develop a public scorecard using claims-based and consumer-reported data to compare quality measures across provider network because the APCD only housed Medicare and some commercial claims, leaving the substantive gap of Medicaid beneficiary data. As of March 2018, the SIM PMO, the HITO, and the DSS were working together to modify a statute to allow the transfer of Medicaid claims to the APCD.

B.2.4 Population health

Key Results
<ul style="list-style-type: none"> • The SIM Initiative began the process of linking CBOs with primary care practices to test whether there were shared savings benefits for both practices and communities. • DPH and SIM staff released an RFP and selected reference communities for the Health Enhancement Community (HEC) initiative. • The Population Health Council, which had struggled with identifying and communicating a vision for the Prevention Service Initiative (PSI) and HEC initiative, was helped in advancing the models by new leadership.

During the AR3 analysis period, the SIM PMO and DPH released a request for applications (RFA) as part of the PSI. The SIM PMO and DPH will use the applications to select CBOs and ANs or FQHCs to establish formal partnerships for the provision of prevention services and began the process of linking CBOs with PCPs. HEC reference communities were selected as test cases, and data collection and analysis efforts got under way to inform the HEC planning process. Under the new leadership approach that is a partnership of PMO and the DPH, the Population Health Council advanced the PSI and HEC models, despite continued stakeholder concern about capacity and duplication of effort. **Table B-6** describes Connecticut's progress on these population health activities.

Table B-6. Connecticut’s progress on population health

Activity	Target population	Key activities	Progress between May 1, 2017, and March 31, 2018
PSI	CBOs and ANs or FQHCs	Linking CBOs with PCPs to test whether there are shared savings benefits for both practice and community	<ul style="list-style-type: none"> Contracted with Health Management Associates. Developed the PSI model. Released RFAs to select CBOs and ANs or FQHCs.
HEC	Multi-sector community collaboratives	HECs assuming accountability for reducing the incidence and prevalence of acute and chronic illness and coordinating the strategies of multisector partners who agreed to make prevention-aligned investments	<ul style="list-style-type: none"> Contracted with Health Management Associates. Released an RFP and selected reference HECs.

AN = Advanced Network; CBO = community-based organization; FQHC = Federally Qualified Health Center; HEC = Health Enhancement Community; PCP = primary care provider; PSI = Prevention Service Initiative; RFA = request for authorization; RFP = request for proposals.

The SIM Initiative began the process of linking CBOs with PCPs to test for any shared savings benefits for both practices and communities. After selecting Health Management Associates to serve as the TA vendor, the SIM Initiative and DPH released RFAs in February 2018 to select CBOs and ANs or FQHCs to establish formal partnerships for prevention services provision. The Population Health Council conducted stakeholder interviews in early 2018 to inform the development of the PSI model and related TA for data analytics and contract negotiations. The Population Health Council also promoted alignment between PCMH+ and the PSI by encouraging PCMH+ PEs to use PSI CBOs to meet their PCMH+ community linkage requirements. Some stakeholders raised the concern that the PSI did not have substantial funding, making it potentially not beneficial to connect health care providers to CBOs already struggling to meet community needs with limited resources and capacity. These stakeholders argued that, to make them effective partners, CBOs needed capacity building assistance related to governance, contractual capabilities, and network development.

DPH and SIM staff released an RFP and selected reference HECs, including New Haven, New London, and Middletown. Health Management Associates was selected as the TA vendor to handle the HEC planning process. The reference HECs, which were chosen based on existing activities and the number of PCMH+ attributed lives in the area, were to be used as test cases to develop a local strategy to be scaled up to the state population. Despite the attempt to align the HEC initiative with PCMH+, stakeholders raised concerns about the roll out of the HEC and the potential to create parallel systems. It was unclear how HECs would interact with PCMH+ providers or how the creation of HECs would interact with existing community-based population health initiatives.

Data collection and analysis efforts were under way to inform the HEC planning process, including the development of a health report covering two urban Connecticut cities, New Haven and Hartford. New questions of interest to the SIM Initiative were added to the state’s Behavioral Risk Factor Surveillance System (BRFSS) relating to asthma, diabetes, and social context. BRFSS staff also analyzed health disparities data and prepared datasets and technical support to update the UConn SIM data dashboard. BRFSS staff created a report using predictive modeling to provide population estimates by town, age, sex, race, and Hispanic ethnicity for the years 2011–2014 to be used for attribution. The PMO sought proposals from bidders to develop a mechanism to identify health equity data and a collection mechanism and to pilot these key data elements within a data and analytics solution.

The Population Health Council had struggled with identifying and communicating a vision for the PSI and HEC initiative, but new leadership provided through a partnership of the SIM PMO and DPH, and new Council membership, helped advance the models. The SIM Steering Committee members struggled with distinguishing between clinical prevention that takes place within a provider’s office and community prevention activities that address the health of the population. According to one stakeholder, “...it was a hard concept to get folks on the Steering Committee, other than the community organizations that were participating, to get them to think outside the walls of the office and get them thinking about community-level initiatives and prevention.”

In response, the SIM Steering Committee approved an updated population health charter to prepare for the HEC planning process and added both a community health improvement strategist and finance expert to its membership. The Population Health team also conducted a stakeholder and interview process to inform the development of its models and scope of work. Several stakeholders indicated that these new membership developments would help advance the models.

“We weren’t as strong as we needed to be on leadership of the Initiative...that turned around earlier this year. We all sat down together, and we decided to co-manage the population health, SIM and DPH are co-managing it now. That turned into a really good team.”

—State official

Nevertheless, some confusion remained about the specific activities of the PSI, HECs, and PCMH+ and how they aligned to support prevention and community health, including concern about the potential for parallel or duplicative systems.

B.2.5 Governance and sustainability

Key Results

- The SIM PMO transitioned to the newly created OHS on February 1, 2018.
- A Consumer Engagement and Communication Plan was developed to support and guide ongoing consumer engagement activities.
- Although substantive improvements in the relationship were made between the SIM PMO and DSS, challenges remained.
- Commercial payers remained minimally engaged in the SIM Initiative.

The SIM Initiative’s administration transitioned from the Office of the Healthcare Advocate (OHA) to the newly created OHS in February 2018.¹⁴ Also in February, the previous state Healthcare Advocate was named as executive director of the OHS; she provided strong SIM continuity because of her involvement with

the SIM Initiative from the beginning. The new OHS brought together the SIM Initiative, health IT, the APCD, and the Office of Health Care Access. The Office of Health Care Access manages the certificate of need process that provides approval for substantial capital investments and changes in services for certain types of health care providers, statewide facility planning, and hospital data reporting. The OHS, highlighting the SIM Initiative as a key initiative, provides a comprehensive vision for Connecticut’s long-term health reform goals by emphasizing coordination across multiple agencies, leveraging shared data and resources, and generating ideas and programs that could be sustained across multiple political administrations.

“I think making it [SIM Initiative] part of the overall strategy for the state is a huge advantage and sends a message that we’re in it for the long haul.”

—State official

Stakeholder engagement

The PMO held several consumer events, including a forum focused on diabetes within the black and African American community, a youth summit for young adults with disabilities, and an asthma forum. The Consumer Advisory Board developed a Consumer Engagement and Communication Plan to support and guide ongoing consumer engagement activities—an area the PMO identified as a key component of SIM sustainability. One consumer advocate highlighted the value of the Consumer Engagement and Communications Plan, saying, “...this stuff is so complicated that being able to put it together in a concise message for legislators, for the public, is absolutely essential.”

While Connecticut stakeholders commended the PMO for its stakeholder engagement efforts, not all stakeholders participated in or supported the SIM Initiative. Consumer advocates opposing managed care and value-based approaches to payment and

¹⁴ The SIM award was officially transferred from OHA to OHS on June 1, 2018.

delivery, who are very vocal in Connecticut, were successful in delaying the rollout of the Medicaid SSP. Additionally, several interviewees noted that pushback from these consumer advocates—whose perspective is informed by Connecticut Medicaid’s prior history of moving from capitated managed care to a fully FFS model—was instrumental more generally in making SIM implementation more challenging.

In the coming year, the PMO plans to further expand its effort to engage consumers by ensuring that culturally relevant information and tools are available while also prioritizing communications to the most disenfranchised communities. The SIM Initiative leadership plans to continue listening sessions including consumer engagement forums in partnership with other consumer organizations, compiling key messages from past listening sessions to share with community groups, and disseminating specific messages from community members through issue-based convenings, videos, and testimonials. The planning also included the development of tutorials to inform consumers and other community members about how to interpret and use the findings of the public scorecard and consumer experience survey.

Although multiple stakeholders felt the relationship between SIM leadership and DSS had improved substantially, challenges remained.¹⁵ One interviewee described the DSS as “reluctant participants” and questioned the DSS’s buy-in to several aspects of the SIM Initiative, from payment reform to health IT. This interviewee explained that the “absent strong support” from the DSS left the SIM leadership team to move the agenda forward on their own to gain traction and momentum any way they could. The same interviewee felt there were too many programs underway, which was diluting the focus, not only of the SIM leadership team but of SIM participants. “I don’t think they’d be in this position if they had support. Because they’re winners and they’re not going to let this thing lose. They’re looking for every button they can push.” Feedback from the PEs echoed this frustration with the DSS, particularly around new reporting metrics, which they felt were sprung upon them, and the expectations for an audit, about which the PEs received no clear communication. Despite their frustration, the PEs did note that as the SIM programs matured, consistency and collaboration between the two offices and with the PEs were improving.

Sustainability

Commercial payers remained minimally engaged in the SIM Initiative, creating an issue for sustainability. While most major insurers continued to have representation on committees and workgroups, there was no significant commercial buy-in or commitment to key multi-payer strategies such as quality measure alignment. One interviewee described the

¹⁵ CMS. (2017). *State Innovation Models Round 2: Model Test Annual Report Two*. Retrieved from <https://downloads.cms.gov/files/cmimi/sim-round2test-secondannrpt.pdf>

situation thus: "...a lot of plans seemed like they were sending government relations people [to SIM meetings], they were not sending their lead clinical people or their decision makers."


Continued reliance on voluntary participation of payers might impact SIM sustainability. One state official noted that Connecticut had not adopted policies (e.g., legislation, executive orders) protecting payers from the risk of violating antitrust law in multi-payer reform initiatives, which could negatively impact leveraging some large health care systems to participate. Another state official noted an additional sustainability concern: "...we're not forcing them [to participate], which is another issue. Someone could say that's a problem, too. We're not using regulatory levers to force it. At least yet."

State budget challenges continued to affect the Medicaid program and Medicaid providers. Limited resources affected—and, according to stakeholders, would continue to affect—PCMH+ implementation throughout the state, particularly among providers in ANs who would continue to not receive advanced payments for attributed lives. Additionally, although Connecticut extended the primary care rate bump from the Affordable Care Act beyond the required 2 years, that rate bump was cut to 95 percent and was expected to be cut again (down to 90 percent). The 2018 budget also reduced Medicaid benefits for the state's seniors and disabled individuals.¹⁶ As reported in previous years, in the AR3 analysis period, hospitals once again identified inadequate Medicaid reimbursement as a challenge to providing services and participating in demonstration initiatives.

B.3 Implications of Findings/Lessons Learned

The Connecticut SIM Initiative achieved four major milestones during the AR3 analysis period:

- PCMH+ completed Wave 1, and Wave 2 was expected to launch in May 2018.
- The AMH program was discontinued because of low participation, with resources repurposed to CCIP TA awards.
- Health IT came under new leadership in January 2017, with a stronger vision of progress.
- VBID provided TA to 11 employers.

¹⁶ Radelat, A. (2017, November 2). CT budget cuts program that helps low-income and disabled Medicare patients. *The CT Mirror*. Retrieved from <https://ctmirror.org/2017/11/02/ct-budget-cuts-program-that-helps-low-income-and-disabled-medicare-patients/> 

Based on the SIM implementation experience, stakeholders offered several opportunities, remaining challenges, and lessons learned for other states:

- Shared savings took longer than anticipated to be realized.
- Integration, alignment, and communication among programs increased the pace of SIM implementation.
- The discontinuation of underperforming models and reallocation of those resources helped strengthen the overall SIM program in Connecticut.
- Health IT infrastructure and leadership were essential for practice transformation and payment reform initiatives.
- Stakeholder engagement activities strengthened implementation activities but slowed down prior planning progress.

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Appendix C: State Innovation Model in Model Test States: Delaware

Key Results from Delaware's State Innovation Model Initiative May 2017–March 2018

Strategies, progress, and accomplishments, May 2017–March 2018

- Purchasing levers were used to advance Medicaid payment reform.
- Payer and provider readiness was assessed, and payment models and purchasing strategies were refined.
- Health care cost and quality benchmarks for monitoring spending and quality were developed.
- Primary care providers (PCPs) achieved practice transformation milestones, implementing changes that increase their capacity to deliver more coordinated and integrated care.
- A behavioral health electronic health record (EHR) grant and workforce development activities were terminated.
- The state's health information exchange—the Delaware Health Information Network (DHIN)—began developing the Delaware Health Care Claims Database (HCCD) proof-of-concept testing.
- The behavioral health integration (BHI) pilot program became operational and provided technical assistance (TA) for the integration of behavioral health with primary care.
- The SIM Initiative hired a contractor, Health Management Associates (HMA), to implement both the Healthy Neighborhoods (HNs) and BHI strategies, creating structures and processes to facilitate the implementation of HNs and managing the BHI pilot.

Stakeholder response to implemented strategies

- PCPs implemented transformed practice features such as extended hours, a team approach, care coordination, and promotion of healthy behaviors.
- Large providers implemented care management for patients in preparation for value-based payment (VBP).
- Nearly all providers regularly used the DHIN, but the costs of contributing data limited provider contributions.

Remaining challenges

- Health systems and PCPs expressed frustration about the slow pace of VBP implementation by payers. PCPs said that the current level of reimbursement was not sufficient to support practice transformation.
- HCCD development remained in an early stage, and provider Common Scorecard use remained low.
- Lack of health system competition and inadequate payer information speed and accuracy were cited as barriers to VBP implementation.
- No clear strategy was in place to build workforce capacity.

Sustainability after the SIM award

- The state planned to sustain VBP through Medicaid and state employee health insurance program contractual requirements, and to cover the HCCD through access fees and grant funding.
- Tobacco settlement or private entity funding might support the health care cost and quality benchmarking effort.

Delaware’s SIM Initiative began on February 1, 2015. SIM Initiative leaders intended to use the award to address the high per capita cost of health care in the state; improve the health, health care quality, and patient experience of all Delawareans; and improve provider satisfaction. To accomplish its goals, the state accelerated change through a multi-stakeholder approach, focusing its SIM Initiative efforts on VBP models, care coordination, practice transformation, BHI, and HNs.

This updated overview of the Delaware SIM Initiative is based on an analysis of data collected from site visits, stakeholder telephone interviews, state document reviews, and state program and evaluation calls conducted between May 1, 2017, and March 31, 2018, the current analysis period. Additional details about the analytic approach are available in *Chapter 1*. Information about the number and types of stakeholders interviewed for the state is in *Table 1-1*. *Figure C-1* depicts the timeline of major Delaware SIM and SIM-related activities to date.

C.1 Key State Context and Progress Prior to May 2017

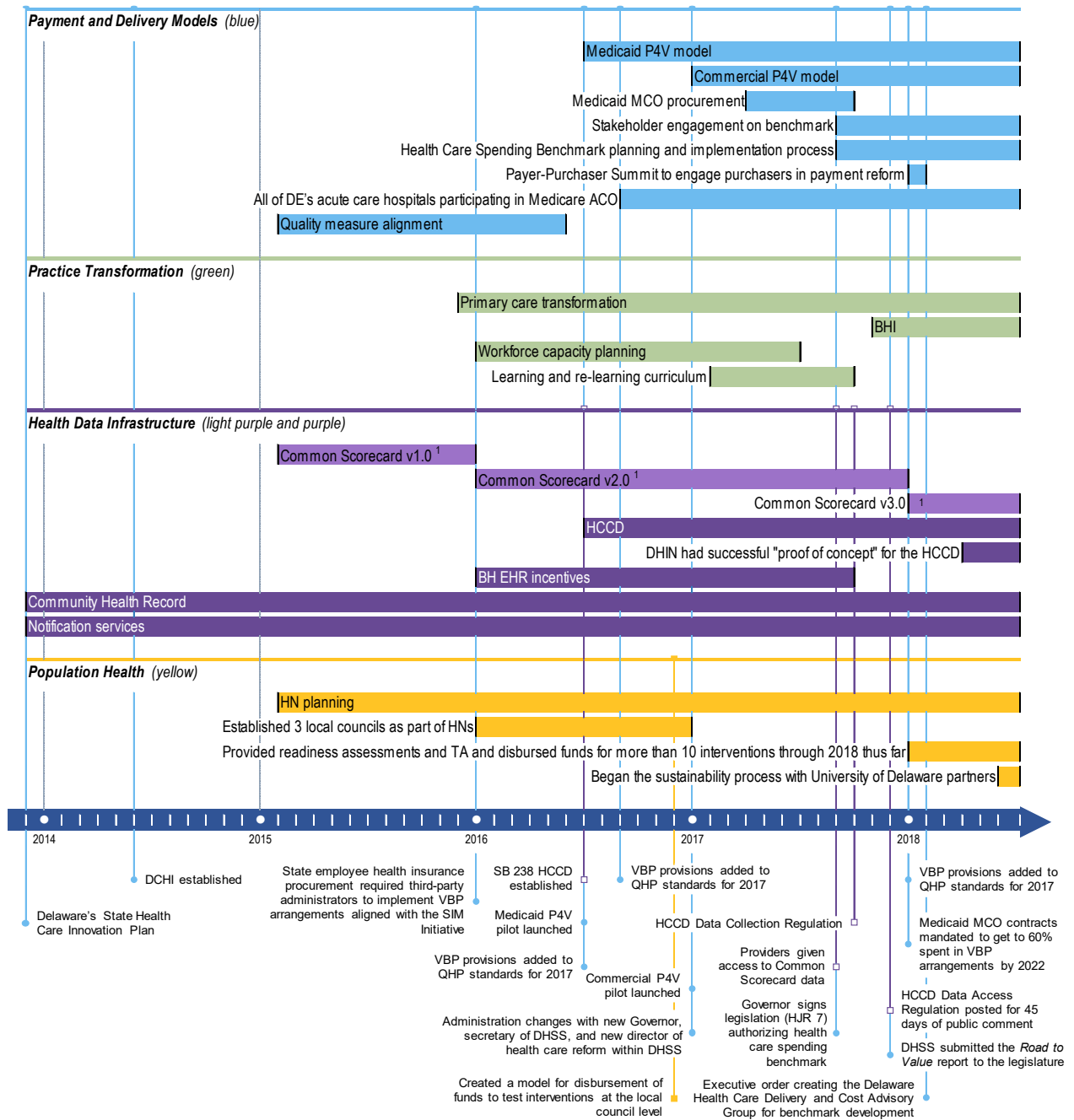
C.1.1 Pre-State Innovation Model health care in Delaware

The Delaware health care system—which varied greatly across the state in access, utilization, and costs—consisted of three payers and three major health systems, with one payer and one health system dominating the market. Health systems in Delaware’s three sociodemographically diverse geographic regions addressed the unique health needs within subsets of their community but still left coverage gaps. The three sociodemographically diverse geographic regions are the northern region (predominantly urban), the central region (suburban), and the southern region (rural with migrant and seasonal tourist populations). Delivery was fragmented across the main health systems, including six hospitals and a Veterans Affairs hospital. Each system built its own referral base and expertise, and lessons were not shared across systems.

Much of the state falls within designated Health Professional Shortage Areas for primary care and dental care. Access to psychiatrists and other behavioral health professionals was lacking, especially in the southern rural areas of the state, which also needed more PCPs. Approximately 10 percent of Delawareans lacked health insurance, with a slightly higher rate in Sussex County, the southern portion of the state. At the start of the SIM award, approximately half of Delaware’s eligible population were enrolled in marketplace coverage.¹

¹ Delaware Health and Social Services (DHSS), Division of Public Health. (2016, February). *Delaware primary care health needs assessment 2015*. Retrieved from <https://dhss.delaware.gov/dph/hsm/files/depchealthneedsassessment2015.pdf>

Figure C-1. Timeline of Delaware State Innovation Model and State Innovation Model-related activities



Note: Lighter shades (with ¹) of the same color bars denote similar activities or models.

ACO = accountable care organization; BH = behavioral health; BHI = behavioral health integration; DCHI = Delaware Center for Health Innovation; DE = Delaware; DHIN = Delaware Health Information Network; DHSS = Delaware Health and Social Services; EHR = electronic health record; HCCD = Health Care Claims Database; HJR = House Joint Resolution; HN = Healthy Neighborhood; MCO = managed care organization; P4V = pay for value; QHP = qualified health plan; SB = Senate Bill; SIM = State Innovation Model; TA = technical assistance; VBP = value-based payment.

C.1.2 State Innovation Model Initiative progress and changes prior to the Annual Report 3 analysis period

Delaware’s SIM Initiative focused on accelerating change through a multi-stakeholder approach that included multiple payer types and health systems. SIM’s governance and financing structure supported a voluntary, consensus-based approach, complemented by the state’s use of its regulatory and purchasing authority to motivate and support change. In addition to the SIM Initiative, three Delaware hospitals participated in the Bundle Payments for Care Improvement Initiative Model 2, and several other providers took part in the Transforming Clinical Practice Initiative. The Delaware eBrightHealth ACO (accountable care organization)—with five health care systems, 20 community-based primary practices, and one Federally Qualified Health Center (FQHC)—participated in the Medicare Shared Savings Program (MSSP).

The two VBP concepts that the SIM Initiative developed (i.e., pay for value [P4V] and total cost of care [TCC]) relied on voluntary implementation by payers. At the end of the Annual Report 2 (AR2) analysis period, the state’s largest payer had implemented a P4V payment model, with some larger primary care practices serving Medicaid and commercial plan members; another payer had implemented a P4V model for Medicaid beneficiaries served by a limited number of pediatric practices.

C.2 Progress and Accomplishments from Delaware’s State Innovation Model Initiative, May 2017–March 2018

C.2.1 Delivery models and payment reforms

Key Results
<ul style="list-style-type: none">• Delaware added target percentages for Medicaid expenditures in VBP arrangements.• The state procured a vendor, Mercer Health & Benefits, to assess payer and provider readiness and refine payment models and purchasing strategies.• Development began on health care cost and quality benchmarks for monitoring cost growth and quality.• PCPs participating in practice transformation implemented extended hours, a team approach, care coordination, and promotion of healthy behaviors.• Large providers implemented care management for patients in preparation for VBP.• Nearly all providers regularly used the DHIN.• The BHI pilot program was implemented.

Implementation of value-based payment in Medicaid

Delaware continued to make progress toward its goal of implementing VBP, although implementation was slower than anticipated (*Table C-1*). State officials noted the lack of VBP participation by payers and the lack of competition among payers and large providers as two major challenges. In response, the state strengthened VBP provisions in Medicaid contracts and started developing health care cost and quality benchmarks. The state assisted PCPs with preparing for VBP by providing practice transformation assessments and coaching and by launching a BHI pilot program (*Section C.2.3*).

Table C-1. Delaware’s progress on delivery system and payment reforms

Activity	Target population	Key activities	Progress between May 1, 2017, and March 31, 2018
VBP	Delaware Medicaid beneficiaries	Using purchasing levers Health care cost and quality benchmarks	<ul style="list-style-type: none"> • VBP provisions were strengthened in Medicaid contracts, including adding targets. • Contracts required payments for coordinated care. • HJR 7 was passed to develop an annual benchmark and recommendations to reduce the rate of cost growth. • Five stakeholder meetings were held for measure input.
Delivery reform	Primary care physicians and practices	Participating in practice transformation Sharing patient information Integrating BH and physical health	<ul style="list-style-type: none"> • PCPs completed the nine modules and milestones of practice transformation. • Nearly all providers regularly used the DHIN. • A four-track BHI pilot program was implemented.

BH = behavioral health; BHI = behavioral health integration; DHIN = Delaware Health Information Network; HJR = House Joint Resolution; PCP = primary care provider; VBP = value-based payment.

Delaware used purchasing levers to advance Medicaid payment reform. State officials reported that the VBP provision in the Medicaid contract with MCOs that was effective January 1, 2018 includes targets for the percentage of expenditures in VBP each year; the previous contract required that MCOs implement P4V and TCC models but did not set specific VBP targets. Some ACO providers expressed frustration that an opportunity to accelerate VBP adoption was missed when the state failed to select a bid from an MCO partnering with that ACO.

State officials and stakeholders expressed differing views about the barriers and challenges to VBP implementation. State officials cited lack of competition among health systems. Some large providers dominated their markets, enabling them to avoid risk and/or slow down the pace of change because payers could not afford to exclude such large providers from

their networks. A hospital stakeholder said that hospitals were ready to assume more risk, but the payers were not prepared: “It’s hard to get information from the insurance companies in terms of speed and accuracy ... and they’re just not that far up the curve in dealing with risk payment models.”

To address these challenges the state procured a vendor, Mercer Health & Benefits, to assess the readiness of payers and providers to participate in payment reforms and help the state refine its payment models and purchasing strategies. State officials also explored the appropriate Medicaid authority to authorize Medicaid VBP and considered a coordinated purchasing approach between Medicaid and the state employee health insurance program. In the coordinated purchasing approach, VBP would be sustained through contractual requirements and financed through Medicaid capitation rates and the state employee health insurance program.

Health care spending and quality benchmarks

In September 2017, the Governor signed HJR 7, which instructs the DHSS Secretary to begin developing an annual cost benchmark and to recommend solutions to reduce spending growth. The cost benchmark was described as a tool to raise awareness of health care costs, increase provider and payer accountability for rising costs, and advance the state’s efforts to implement payment reform. The state would then use selected measures from the Common Scorecard to compare market, payer, and provider performance each year to the benchmarks.² The benchmark could be used to regulate costs, but only as a last resort. Mercer Health & Benefits assisted the state with developing the benchmarks.

“The work on the healthcare spending benchmark has given us an opportunity to talk about health care spending in a different way...I think there was a bit of a stall around payment reform strategy that was re-energized when we decided to move forward with the benchmark to talk more openly about the spending, as well as the significant budget shortfall.”
—State official

Although several interviewees mentioned that the cost benchmark alarmed some providers, the provider interviewees did not express such concern, although they said that work on the benchmark delayed VBP implementation.

After the legislation was signed, the state held a series of five health care summits to engage a range of stakeholders to provide input into the benchmark planning. DHSS staff prepared a report titled *Delaware’s Road to Value*, which recommended strategies to improve health and transform health care delivery, and delivered it to the legislature in December 2017. In February 2018, the Governor signed an executive order creating the Delaware Health Care Delivery and Cost Advisory Group, chaired by the Secretary of the state’s DHSS and comprising

² Delaware Health Care Delivery and Cost Advisory Group. (2018, April 2). *Quality Benchmark Subcommittee*. Retrieved August 24, 2018, from <https://dhss.delaware.gov/dhcc/files/qualitybenchmark.pdf>

state officials; provider, insurance, and employer stakeholders; and a health economist. This advisory group was tasked with advising the Secretary about the creation of both cost and quality benchmarks and held its first meeting in March 2018. The group’s mandate is scheduled to end June 30, 2018, unless the Governor issues an extension.

For sustainability, the state plans included either using tobacco settlement monies to help fund post-SIM benchmark work or seeking funding from private entities interested in monitoring health care costs—with political sustainability coming from the state’s efforts to engage business leaders and key legislators. State leaders engaged the public about the need for accountable health care, citing the Governor’s State of the State address and a “stump presentation” the DHHS Secretary used for multiple audiences.

Delivery system change

Provider representatives and participants in two provider focus groups and two consumer focus groups indicated that changes were under way, but were disappointed about progress made to date.

Two large provider organizations participating in an ACO took major steps to improve their ability to coordinate care and improve population health. Both provider organizations applied the same care management methods to all patients, not just those under a risk contract. One of the two organizations increased its data management and analytics capacity because data had identified the need to work with providers outside its system. For example, the organization started working with skilled nursing facilities to improve post-acute care.

Primary care practices implemented changes to increase their capacity to deliver more coordinated and integrated care. Most of the PCPs participating in focus groups said their practices implemented extended hours, a team approach, care coordination, and promotion of healthy behavior. Some practices co-located behavioral health providers. State employees in focus groups confirmed the PCPs’ reports—with such examples as PCPs having evening hours and promoting healthy behaviors, providing referrals to nutritionists, and sending reminders about preventive services or screening for mental health issues.

Nearly all provider focus group participants regularly used the DHIN. Some focus group participants used the DHIN to avoid requesting tests previously ordered by other providers. Some participants used an ACO portal that allows them to access patient information such as admission, discharge, and transfer notices. However, some providers said the continuity of care documents accessed through the DHIN were not useful because they were difficult to read, and some did not submit data because their practices believed that the submission fees were too high.

Although many larger providers had completed practice transformation milestones, they expressed frustration about the slow pace of payment reform to support and incentivize their efforts. Moreover, many small and independent providers in the state did not participate in the practice transformation initiative because they could not meet the challenges of investing in infrastructure and implementing care coordination.

Providers said the care coordination payments were insufficient to support the required implementation changes. Medicare payments for chronic care management (CCM) had become an important source of revenue for care coordination. For example, two practices were each providing CCM services to more than 300 patients and had reassigned staff to coordinate care for patients receiving CCM. Providers complained that other payers had been slow to implement VBP initiatives that would reward them for providing VBP and that the fees that commercial payers paid for primary care services were lower than Medicare and Medicaid fees, leaving practices with limited funds for transformation.

ACO PCPs in the provider focus groups complained that utilization beyond their control was counted against them in one payer’s VBP model. For example, providers said that they were unhappy that urgent care center utilization was counted against them, even though patients had no disincentive to use an urgent care center instead of an office visit. Patients might go several years between PCMH visits, for example, because it was convenient to use an urgent care center or visit a public health clinic for immunizations. Many providers said they lacked hope about the future of independent practice because of inadequate payments and other issues, noting that some PCPs were switching to concierge medicine, whereas others were taking jobs as salaried physicians.

“Some of the reason that [practice transformation] is not as effective or successful as we’d like it to be is because payment reform did not go in lock step with it ... In the end, the practices still had to put out the money, they had to put out the capital, they had to put out the manpower.”
—Provider

Delaware implemented its BHI pilot program. The BHI pilot program enabled practices to engage in four coaching tracks along the continuum of coordinated care to better integrate behavioral health into their practice and to prepare to participate in VBP. For more information about the BHI pilot model, see *Section C.2.3*.

C.2.2 Progress toward a preponderance of care in value-based payment and alternative payment models

Key Results

- Although behind schedule, Delaware state officials and stakeholders said they have made significant progress toward moving 80 percent of the population into VBP.
- State agencies made greater use of contractual levers.
- The groundwork was laid, and large providers supported the move to VBP.

Delaware was confident that the state would achieve preponderance of care.

Delaware state officials and large providers generally agreed their state was behind schedule regarding achieving preponderance of care. However, the officials were optimistic that the changes under way laid the groundwork to achieve preponderance of care, though not necessarily by the end of the model test period.

Several measures supported the shift to VBP. The new Medicaid contract included targets for the percentage of spend under VBP arrangements, and state officials were considering closer alignment between Medicaid and state employee plan purchasing. Some state officials also described the cost benchmark as a lever for the adoption of VBP.

The Medicare, Medicaid, and state employee populations together comprised a significant portion of the state’s population, and in the words of one provider, implementing VBP for those three populations could “move the needle forward in a really big way.” However, according to several state officials, the state’s dominant payer, Highmark, with approximately 60 percent of the commercial market, could potentially drive change, but had moved forward slowly.

“We will make very good progress in the next couple of years. The new Medicaid contract alone will drive our population to value-based care arrangements, because we have some pretty intense requirements around total percentage spend that has to go into these arrangements.”

—State official

Large providers emphasized their current participation in multiple VBP arrangements and their readiness to take on risk. One of the large providers noted that many of the state’s providers participated in ACOs and added that “[w]e didn’t do all this work just to have an MSSP contract. There is a huge infrastructure prepared for value-based payment that’s waiting to be used and engaged.”

Table C-2 presents the extent to which Delaware’s population participated in alternative payment models (APMs) as reported by the state in its Award Year 3, Report 4 progress report to CMMI.³ Statewide, Delaware reported that 256,232 individuals (30.7 percent of the state’s insured population and 27.4 percent of the total state population) were impacted by VBP or APMs aligned with the SIM Initiative. This number represents an increase of more than 100,000 individuals since the previous analysis period.

Table C-2. Populations reached by a value-based payment or alternative payment model in Delaware, latest reported figures as of Award Year 3, Annual Report

Payer type	SIM models			Landscape
	PCMHs	ACOs	SIM Initiative-wide	Any VBP or APMs
Statewide	—	—	—	256,232 ¹ (27.4%)

Source: Delaware SIM Initiative Quarterly Progress Report for Award Year 3, Report 4.

— = relevant data not provided in the data source; ACO = accountable care organization; APM = alternative payment model; P4V = pay for value; PCMH = patient-centered medical home; SIM = State Innovation Model; VBP = value-based payment.

¹ Individuals receiving care through any VBP and APM aligned with the SIM Initiative, including True Performance (P4V model), PCMH, Basic Quality (payment model tied to quality), and Accountable Care Shared Savings Model (P4V model).

Note: The denominator is provided by United States Census American Community Survey 5-Year Estimates (<https://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml>; accessed on May 31, 2018). The state reported that it reached 30.7% of the targeted population, which is the total number of beneficiaries targeted for inclusion in a Category 2 or Category 3 payment model (833,365).

Table C-3 presents the extent to which Delaware’s payers were participating in the VBP or APMs as defined by the Learning and Action Network categories, as provided by the state in its Award Year 3, Report 4 progress report to CMMI. As shown in **Table C-3**, the two Medicaid plans (i.e., Highmark and UnitedHealthcare) lagged behind Medicare fee for service (FFS) and the Highmark and Aetna Commercial plans at the end of Award Year (AY)3. The state addressed this issue by adding percentage targets to the VBP provision in the Medicaid MCO contract. UnitedHealthcare was not selected for a Medicaid contract for 2018 and beyond, which some state officials and stakeholders said might slow VBP expansion for the Medicaid population because the new Medicaid MCO, AmeriHealth Caritas, would have to establish its own VBP arrangements with providers.

³ Because these data values were not verified by CMMI, the RTI team cannot attest to their accuracy.

Table C-3. Payers participating in a value-based payment or alternative payment model in Delaware, latest reported figures as of Award Year 3

Payer	Category 1 Payment: FFS with no link of payment to quality		Category 2 Payment: Payment linked to quality		Category 3 Payment: APMs		Category 4 Payment: Population-based payment	
	Number of beneficiaries	Percentage of payments	Number of beneficiaries	Percentage of payments	Number of beneficiaries	Percentage of payments	Number of beneficiaries	Percentage of payments
Medicare (FFS)	90,000	—	—	—	66,115	40%	—	—
Medicare Advantage	16,700	—	—	—	—	—	—	—
UnitedHealthcare—Medicaid	63,412	—	15,740	—	12,650	—	—	—
Highmark—Medicaid	78,989	74%	—	—	36,122	26%	—	—
Highmark—Commercial	187,156	49%	—	—	125,110	51%	—	—
Aetna—Commercial	95,000	46%	—	—	52,000	54%	—	—

Source: Delaware SIM Initiative Quarterly Progress Report for Award Year 3, Report 4.

— = relevant data not provided in the data source; APM = alternative payment model; FFS = fee for service; SIM = State Innovation Model.

Table C-4 presents the number of Delaware providers participating in the SIM payment and health care delivery models, as provided by the state in its Award Year 3, Report 4 progress report to CMMI. The state reported that 365 physicians (36.5 percent of the AY3 target) were involved in VBP or an APM aligned with SIM-supported goals. The state also reported that five ACOs or hospital systems were involved in VBP or an APM aligned with SIM-supported goals, constituting 83.3 percent of their Award Year target of six providers. The number of ACOs and hospital systems participating in VBP increased from four during AY2 to five during AY3.

Table C-4. Providers participating in a value-based payment or alternative payment model in Delaware, latest reported figures as of Award Year 3 Annual Report

Provider type	SIM models			Landscape
	PCMHs	ACO	SIM Initiative-wide	Any VBP or APMs
Providers	—	—	—	365 (36.5%)
Provider organizations	—	—	—	5 (83.3%)

Source: Delaware SIM Initiative Quarterly Progress Report for Award Year 3, Report 4.

— = relevant data not provided in the data source; ACO = accountable care organization; APM = alternative payment model; PCMH = patient-centered medical home; PCP = primary care provider; SIM = State Innovation Model; VBP = value-based payment.

Note: The denominator for providers is the total number of individual PCPs in the state. The denominator for provider organizations is the total number of ACOs and hospital systems.

C.2.3 Enabling strategies to support health care delivery transformation

Key Results
<ul style="list-style-type: none">• Delivery transformation activities shifted resources from the behavioral health EHR grant and workforce development to accelerating payment reform.• Payer-furnished performance report findings differed from Common Scorecard results.• Provider use of the Common Scorecard remained low.• The HCCD remained in the early stages of development.• The DHIN developed HCCD proof-of-concept tests to demonstrate the platform’s capacity to house and share claims data.• Sustaining the HCCD would likely be covered after the SIM Initiative through access fees and grant funding.• Practice transformation training closed enrollment but continued to provide support through the state’s four vendors (i.e., MEDALLES, MedNet/MSD and Health TeamWorks, New Jersey Academy of Physicians and Delaware Academy of Physicians, and Remedy HealthCare Consulting, LLC).• The BHI pilot program became operational and provided support for integrating behavioral health in primary care and community behavioral health sites.• The University of Delaware workforce development program was terminated.• The state implemented studies about workforce development and sustainability.

Delivery transformation continued to progress, although some strategic priorities shifted. The state continued work on the Common Scorecard and planned, during second quarter 2018, to publicly release its aggregate data to increase transparency in connection with the upcoming health care spending benchmark. The HCCD encountered delays because of stakeholder hesitancy, but its technical elements were expected to be functional during May 2018. To reallocate resources to payment reform, the behavioral health EHR grant and workforce development activities were terminated, partly because of its low participation. Practice transformation, including practice coaching and assessments, continued to be a focus for PCPs, and the state also launched the BHI pilot program, with four coaching tracks (*Table C-5*). Participation in practice transformation and BHI activities was good, but no reimbursement beyond free training and TA made it difficult for providers to fully engage in those activities.

Table C-5. Delaware’s progress on enabling strategies to support health care delivery transformation

Activity	Target population	Key activities	Progress between May 1, 2017, and March 31, 2018
Health IT and data	All Delaware health care providers and the public	Common Scorecard	<ul style="list-style-type: none"> Planning to provide public facing aggregate data was under way.
Health IT and data	All Delaware health care practices	HCCD	<ul style="list-style-type: none"> The state promulgated the final regulation regarding data access in the March 2018 register. Proof-of-concept tests were developed. Data use and interagency agreements for data access were carried out. Plans to change from fee-to-submit to fee-to-access cost structure were developed.
Practice transformation and BHI training	Primary care practices and behavioral health providers	Assistance to practices to support their transformation activities	<ul style="list-style-type: none"> Enrollment for the practice transformation program closed. Implemented the BHI pilot program.
Workforce development	Health care workforce	Identifying trends in training and education	<ul style="list-style-type: none"> The University of Delaware workforce development program was terminated. A work group to study workforce sustainability was formed. A PCP workforce capacity survey was planned.

BHI = behavioral health integration; HCCD = Health Care Claims Database; health IT = health information technology; PCP = primary care provider.

Health information technology

Efforts to procure value from the established Common Scorecard and to establish a foundation for the HCCD continued. Although the notification and alert system provided by the DHIN was not funded by the SIM Initiative, it was heavily used and viewed as an important tool for supporting Delaware’s SIM work. One previous health IT activity, behavioral health EHR grants, was discontinued because of low participation and to provide additional funds for payment reform.

Changes in state-level administration led to changes in focus and SIM priorities.

New leadership introduced a stronger emphasis on technology use to support all transformation efforts. Adoption of the Common Scorecard for practice transformation provided one example. The purpose of the Common Scorecard was to assess the extent that providers adopted technology and whether technology adoption was associated with improved performance. Similarly, PCPs and behavioral health providers began discussions in support of exchanging

information. There were plans to integrate the HCCD into the DHIN’s tools to support work on benchmark and payment model reform.

The Common Scorecard remained a focal health IT strategy despite, or perhaps because of, implementation strategies. As a companion to the health care spending benchmark, the state planned to provide an aggregate version of the Common Scorecard on its Web site. The aggregate version would not display data at the individual provider level, but the state hoped it would improve spending transparency by bringing together in one place data on chronic disease management, prevention, utilization, and cost of care. The scheduled public release of the Common Scorecard in first quarter 2018 was delayed, while the policies required to launch it were established. The plan was for state contractors to provide the initial public release of the Common Scorecard after comparing payers’ DHIN submissions to Quality Compass (National Committee for Quality Assurance) metrics. In the absence of any discrepancies, the state and DHIN would then consider using Quality Compass for future public reporting. If two did not agree, the DHIN would investigate the cause, and decide which source to use. Meanwhile, the DHIN used National Committee for Quality Assurance data as a benchmark when reporting to individual practices about how their performance compared with that of other practices in their region.

Provider use of the Common Scorecard remained low for several reasons. Performance results in payer-furnished performance reports often disagreed with Common Scorecard results, with providers and practices trusting the payer data over the Scorecard because payment was directly tied to payer reports. The conflicting payer reports also made the Common Scorecard seem unnecessary,

“In our own case, we have not made it a priority for us to look at it. To be honest, it wasn’t tied directly to payment or to anything that really drove it. And so, in the absence of that, it fell to the bottom of the list of things to worry about.”

—Provider organization representative

particularly given that a single payer accounted for almost 70 percent of the commercial market. Additionally, the Common Scorecard data—being at the practice and not at the individual provider level—prevented providers from seeing themselves in the Scorecard data. Finally, the Common Scorecard was often made available only to practice managers, who did not always share all results with providers.

The HCCD remained in the early stages of development. When it was initially determined that the DHIN Board would make data access decisions, stakeholders raised concerns about transparency and other issues. Health systems were apprehensive about Health Insurance Portability and Accountability Act (HIPAA) compliance and concerned competitors would gain access to insider information, thereby undermining their competitive ability. Payers were worried that confidentiality agreements with providers would be violated if financial data were released. As a result, the DHIN Board decided that a subcommittee of the Board, which according to the

DHIN’s bylaws can include non-Board members, would make data access decisions, thereby allowing for involvement in such decisions from outside the DHIN Board. In the March 2018 register, the state promulgated the final regulation about data access, which established who could access the data and under what terms and conditions. The DHIN then changed its focus to carrying out data use agreements with data submitters and interagency agreements outlining how data would be accessed through extracts or reports.

The DHIN worked on developing HCCD proof-of-concept tests to demonstrate the platform’s capacity to house and share claims data. The DHIN wanted to demonstrate that the platform could properly process claims data by extracting clinical proxy data elements from a claim inside the existing clinical application by using personal health records to test the process and run the appropriate queries. Because research was to be one of the primary uses of the HCCD, a second proof-of-concept testing was planned to perform data extracts similar to those that researchers might request. Following successful demonstrations of these processes, the DHIN planned to take the HCCD to scale, learning additional lessons during the scaling-up process. Completion of proof-of-concept testing was expected by May 2018 to enable the DHIN to begin receiving files from reporting entities.

The expectation was for any additional costs of sustaining the HCCD to be covered through access fees and grant funding. Throughout the process of establishing the HCCD, the state and DHIN discussed sustaining the HCCD beyond the SIM Initiative. Many of the conversations involved HCCD-related cost because additional data storage and new software tools for analysts would be required—even though pre-existing infrastructure was considered likely to reduce these costs below the cost of creating an entirely new platform (e.g., an all-payer claims database). The initial plan was for multiple sources to provide funding, including access fees and public and private grant funding.

“DHIN needs to shift the business model from paying to send to paying to get data, so that there is no friction on sending, but they will get charged for the volume they use. This will be a much better deal for the smaller practice and DHIN can set up a fee structure that way. This is a big shift, though.”

—State official

Switching from a fee-to-submit to a fee-to-access cost structure will be implemented to address free rider challenges. Historically, those who sent data to the DHIN incurred a cost, whereas users of data did not. With the growth of Medicaid ACOs in Delaware, most of which did not use a common EHR, providers took on risk and needed to remain informed about their patients. To do so, providers increasingly relied on the DHIN’s health information exchange function, its longitudinal (“community”) health record, and its adoption, discharge, and transfer system—all of which predated the SIM Initiative—to access the needed patient information. The problem was that, although all laboratories and some urgent care centers submitted data to DHIN systems, most practices did not contribute data, at least in part because of data submission fees.

Implementing a cost-to-access structure was chosen as a way to remove this disincentive. To accommodate small practice use, the new fee structure is being designed to set charges according to the volume of use.

Competition between the DHIN’s health IT tools and tools developed by health systems and EHR vendors. Although health systems had their own tools, the systems were also frequent users of the DHIN’s health IT tools. EHR vendors also offered to handle clients’ clinical quality measures, thereby creating competition for the DHIN’s services. Stakeholders expressed the hope that successful connection of the HCCD with the DHIN’s clinical data would be viewed as a valued resource for providers, payers, and researchers, which would bring more users and funding for the DHIN’s health IT tools.

“In a way, [large health systems are DHIN’s biggest fan and supporter and their] biggest competitor. They rely on [DHIN] for the data but provide ... a roster of people for whom they want the information. Some of the services that DHIN aspires to offer, they are out there offering.”
—State official

Practice transformation

In addition to the practice transformation program, the state launched its BHI pilot program. Payment reform was indicated by state officials and other stakeholders as key to sustainability for both. Workforce development activity was put on pause, while the state focused its efforts on payment reform.

Delaware closed enrollment for practice transformation training but continued to provide support through its four TA vendors. Delaware’s practice transformation strategies continued to focus on helping primary care and behavioral health practices develop integrated behavioral health care and person-centered, team-based primary care. The four vendors that provided individualized coaching and TA were funded by the SIM Initiative at no cost to practices. (Note: The four vendors are MEDALLES, MedNet/MSD and Health TeamWorks, New Jersey Academy of Physicians and Delaware Academy of Physicians, and Remedy HealthCare Consulting, LLC.) The Delaware Health Care Commission used a series of nine milestones to monitor practices’ monthly progress.

Enrollment in the practice transformation program closed on September 30, 2017. As of January 2018, approximately 30 percent of PCPs in the state (106 practice sites and 351 unique providers) were enrolled in the program, with the number of practices set to graduate in 2018 to be determined by the Delaware Health Care Commission.

The BHI pilot program became operational, providing infrastructure coaching to support the integration of behavioral health with primary care services. During October 2017, Delaware awarded a contract to HMA to implement the BHI pilot program, provide infrastructure support, and oversee the SIM Initiative’s HN strategy. The BHI pilot program was

launched in November 2017, with 17 primary care and behavioral health practices enrolled in Cohort 1 (January through July 2018). Between December 2017 and January 2018, each participating practice received a site visit and readiness assessment. In-person collaborative discussions with each practice then occurred (the first during February 2018), after which the practice entered one of four pilot tracks. Each practice was assigned a coach to aid them with achieving their program's particular goals. The practice coach made periodic on-site visits and provided additional support by telephone. TA was also available from HMA subject matter experts. In addition, practices could take advantage of the HMA group learning activities, such as Webinars and in-person collaboratives. Collaboration with practice transformation vendors helped HMA avoid duplication of effort. The Delaware Health Care Commission began recruiting for Cohort 2, whose program activities were scheduled to begin July 2018, and run through December 2018.

Because of a lack of reimbursement for transformation activities, according to stakeholders, physicians in both programs had difficulty dedicating staff time to in-person collaboratives and training or to implementing practice coaches' recommendations. Some providers reported that their practices hired new staff for care coordination services; others, however, reassigned nurses already on staff to care coordination roles. According to the state vendor, reimbursement for practice transformation and care coordination would greatly improve post-SIM sustainability for these efforts.

“And we have small private clinics right now that have joined, that are coming back to us and saying, ‘I’m not sure that we can keep doing this work, keep giving our staff time to learning sessions and all these other things, and hiring or training up people to be behavioral health care managers or contracting with a consulting psychiatrist when we don’t have that reimbursement.’”

—Practice transformation vendor representative

Workforce development

Delaware terminated its workforce development curriculum in September 2017 to focus on payment reform and to study workforce capacity and sustainability. During the first portion of the AR3 analysis period, the University of Delaware staff facilitated health care workforce development through online and in-person learning sessions, completing Modules 1 through 3 of the Learning/Re-learning curriculum project. After that program ended, the state formed a working group within the Delaware Center for Health Innovation (DCHI) Clinical Committee, to study primary care workforce sustainability. To help with this effort, the Department of Public Health planned to conduct a workforce capacity survey of primary care physicians in June 2018.

C.2.4 Population health

Key Results

- The HN strategy was scaled back from 10 to three neighborhoods.
- HMA was hired to implement the HN strategy, creating structures and processes to facilitate HN implementation and developing guidance principles and activities to help HNs plan for sustainability.

Delaware scaled back its HN strategy. Delaware initially proposed 10 HNs with the goal of covering the state’s entire population. With the realization that this goal of 10 HNs was overly ambitious, the state scaled back the strategy to support the three HNs that had already begun operations (i.e., Sussex County, Dover/Smyrna, and Wilmington), still covering the entire state population with these three county-based HNs. Each HN engaged a broad coalition of community partners (*Table C-6*) to identify and address priority health concerns, which included behavioral health, maternal and child health, and chronic disease prevention and management, and through the promotion of healthy lifestyles.

Table C-6. Delaware’s progress on population health

Activity	Target population	Key activities	Progress between May 1, 2017, and March 31, 2018
HNs	Delaware’s population served through the three county-based HNs	Implementation and engagement	<ul style="list-style-type: none"> • Hired a contractor to further develop the HN strategy in three HNs that had already begun operations. • Created a statewide consortium. • Established a streamlined mini-grant process. • Engaged a broad coalition of community partners to identify community priorities. • Developed sustainability guidance principles and activities.

HN = Healthy Neighborhood.

After nearly a year of minimal DCHI progress on the HN initiative, the state contracted HMA to implement the HN strategy. Although the DCHI laid the groundwork for HNs, it did not anticipate the time and effort needed to build a community infrastructure based on trusted relationships. After winning a competitive award over the DCHI, HMA became the contractor for the HN strategy in October 2017. HMA immediately began holding listening sessions across the state to obtain input from a broad range of interested stakeholders. After a year without significant activity—at which point the stakeholders wondered whether the strategy had been abandoned—these listening sessions helped to reinvigorate the HN strategy. Across all stakeholder groups, agreement was unanimous that HMA galvanized the HN initiative’s progress

and expected HMA's approach to addressing the longstanding HN challenges would be successful.

Building on earlier DCHI work, HMA created both structure and processes for the HNs. The proposed structure included a statewide consortium of organizations already working in population health. The consortium was a sounding board for neighborhood-based local councils and specific health focus area task forces as they implemented their individual programs. HMA also established itself as the backbone and statewide fiscal agent for the strategy, developing a straightforward three-step mini-grant process for HNs to request and receive funding for their HN-specific activities, enabling the HNs to focus on improving population health. To support HNs, HMA developed a five-stage TA process to help them through all phases of the HN lifecycle. The phases of the lifecycle range from building their stakeholder base and organizational structure to identifying priority areas; operationalizing plans for specific initiatives, completing readiness assessments, and obtaining funding; and finally, implementing and reporting on their individual initiatives.

HMA helped the HNs plan for sustainability. HMA outlined three HN activities to support sustainability. The first activity was to diversify the stakeholders with whom the neighborhoods engaged by developing strategic partnerships with funders and payers, policy makers, delivery systems, and others. The second activity was to consider lessons learned from sustainability models in other areas, such as a community trust and social impact bonds. The third activity to foster sustainability was to align mini-grant proposals with governmental and nongovernmental funding sources (e.g., hospitals, health systems, banks). One funding source under discussion was nonprofit hospitals' community benefit spending, using a collective impact model in which organizations were strengthened when working together to achieve shared goals.

C.3 Implications of Findings/Lessons Learned

The SIM Initiative achieved four major milestones during the AR3 analysis period, and the use of state purchasing power effectively advanced VBP, despite initially slow payer participation and lack of provider support. These milestones are as follows:

- Practice transformation and workforce development activities were scaled back to enable a stronger focus on payment reform activities.
- Population health activities moved forward in three HN communities with help from an outside contractor, HMA.
- HMA provided structure and adopted processes that stimulated progress within each supported HN.
- Sustainability plans and activities, including fees, grant funding, and state purchasing power, were developed and implemented.

Based on the SIM implementation experience, stakeholders offered several opportunities, identified remaining challenges, and provided lessons learned for other states:

- Payers were slow to implement VBP voluntarily. Use of purchasing levers was an effective way to increase the adoption of VBP.
- Turning data into actionable information remained challenging, especially when health systems and EHR vendors had their own tools that competed with DHIN services.
- The health care cost and quality benchmarks were expected to raise health care cost awareness, increase provider and payer accountability for rising costs, and advance the state's efforts to implement payment reform.
- Stakeholder engagement and coalition building, which were needed to launch the HN strategy, took more time and effort than expected; therefore, states should be careful to allocate sufficient resources to accomplish this type of task.
- Stakeholder engagement should focus on involving all potential parties with a vested interest in the success of the transformation, not only those whose voices are already being heard. Stakeholders noted that the usual players had initially been invited to participate but that a broad-based multi-stakeholder engagement was needed for SIM to be successful.
- Tension between continuing to plan activities and actually launching initiatives diverted stakeholder energy from accomplishing SIM goals in a timely manner.
- Delaware's SIM experience showed that creative thinking about sustainability should include looking at nontraditional funding sources by focusing on organizations and entities with similar goals to those that drove the SIM Initiative.

Appendix D: State Innovation Model in Model Test States: Idaho

Key Results from Idaho's State Innovation Model Initiative May 2017–March 2018

Strategies, progress, and accomplishments, May 2017–March 2018

- The third cohort of clinics engaged in patient-centered medical home (PCMH) transformation was launched, meeting the goal of engaging 165 clinics over the course of the SIM Initiative.
- Ten clinics received first-time PCMH recognition from the National Committee for Quality Assurance (NCQA), for a total of 64 (out of 111) clinics in the first two cohorts with national PCMH recognition.
- Twenty-two virtual PCMHs received recognition, for a total of 28 out of the goal of 50.
- The development of new Medicaid value-based payment (VBP) models continued.
- Twelve telehealth sites and 10 community health emergency medical services (CHEMS) programs were established, and 23 community paramedics and 49 community health workers (CHWs) were trained.
- Bidirectional health information exchange (HIE) connections were made for 69 clinics: 37 from Cohort 1 and 32 from Cohort 2.

Stakeholder response to implemented strategies

- Commercial payer engagement with the Idaho Healthcare Coalition (IHC) and their interest in quality measure alignment increased.

Remaining challenges

- Commercial payers remain reluctant to adopt the PCMH payment model promoted by SIM and adopted by Medicaid, but they continue to develop their own VBP models.
- Cohort 3 clinics, which were less ready for PCMH transformation when they joined the SIM Initiative than previous cohorts, also have less time than previous cohorts to complete the transformation.
- The growth of CHWs and CHEMS continued to be limited by the lack of reimbursement.
- The Idaho Health Data Exchange (IHDE) was behind schedule in connecting clinics to the HIE; the statewide data analytics system was able to produce reports, but the reports were not useable due to data accuracy and completeness issues.

Sustainability after the SIM award

- Strong endorsement for sustaining both PCMH transformation and payment reform was apparent, and stakeholders viewed new Medicaid VBP models as a way to continue supporting PCMH transformation.
- The clinic peer mentorship program provides a vehicle for ongoing practice transformation support.
- The ongoing role of Regional Health Collaboratives (RCs) is uncertain, and stakeholders expressed concern about the ability to sustain CHWs and CHEMS absent payment for the services.

Idaho’s SIM Initiative, which began on February 1, 2015, aims to improve health outcomes, improve quality and patient experience of care, and reduce health care costs—with the goal of transforming Idaho’s health care delivery system to one based on PCMHs operating within an organized medical-health neighborhood.¹

This updated overview of the Idaho SIM Initiative is based on analysis of data collected from site visits, stakeholder telephone interviews, state document reviews, and state program and evaluation calls between May 1, 2017, and March 31, 2018, the Annual Report (AR)3 analysis period. Further details on the analytic approach are available in *Chapter 1*. Information on number and types of stakeholders interviewed for the state is in *Table 1-1*. *Figure D-1* depicts the timeline of major Idaho SIM and SIM-related activities to date.

D.1 Key State Context and Progress Prior to May 2017

D.1.1 Pre-State Innovation Model health care in Idaho

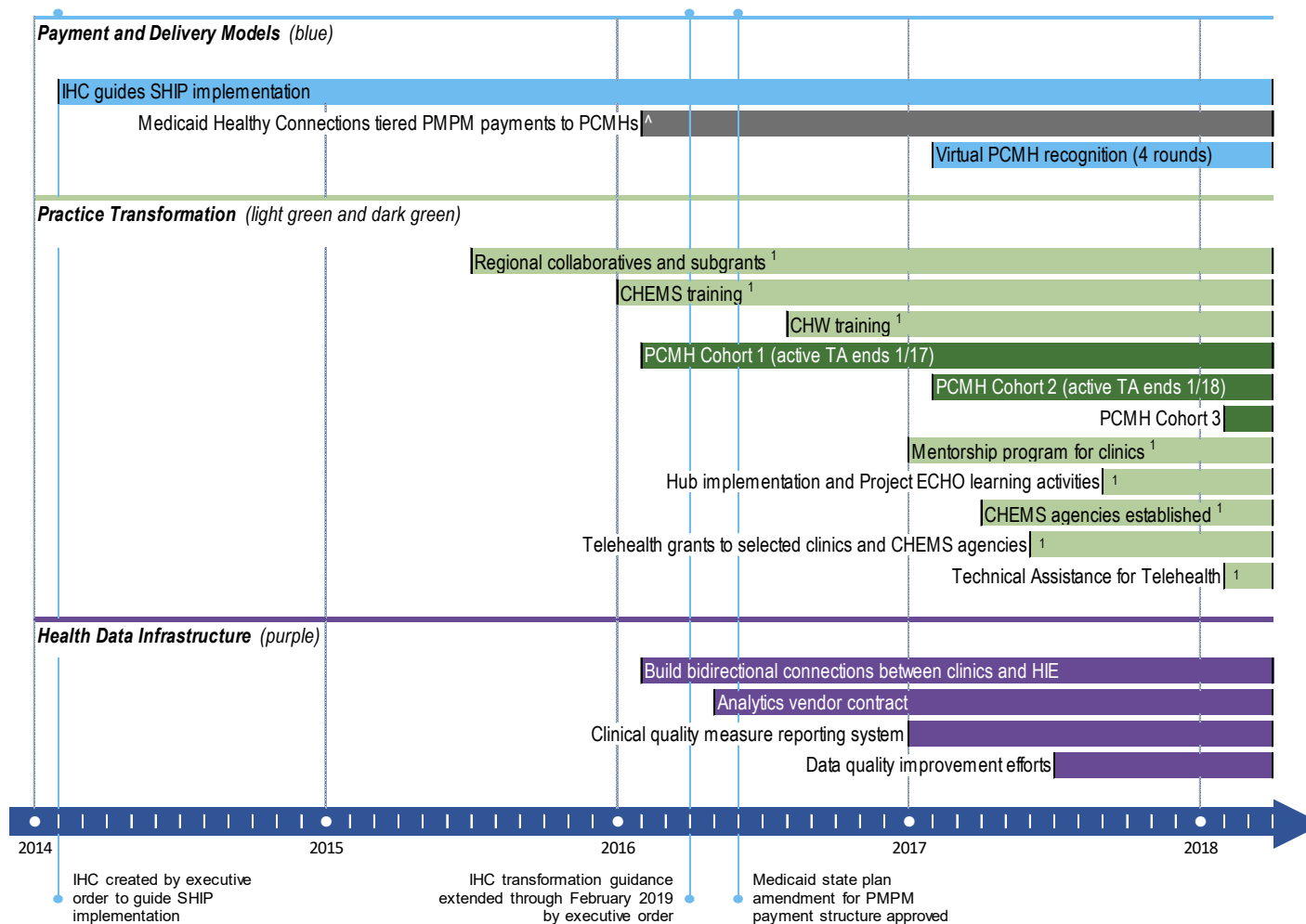
Two key features in Idaho’s health care environment were particularly relevant to its SIM Initiative. First, Idaho is a rural state with a shortage of both primary care providers (PCPs) and behavioral health providers. Second, the public and private sectors in Idaho have a long history of working together to advance the PCMH model. In 2009, the state received a grant from the Commonwealth Fund to help transform 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. Since 2009, Idaho has secured another Commonwealth Fund grant, plus support from the Agency for Healthcare Research and Quality and others, to continue the PCMH expansion efforts.

D.1.2 State Innovation Model Initiative progress and changes prior to the Annual Report 3 analysis period

Idaho’s SIM Initiative built on the state’s extensive previous efforts to implement and spread PCMHs statewide. To achieve that goal, Idaho provides assistance to clinics seeking to transform their delivery of care and established a statewide system of RCs to foster quality improvement (QI) by PCMHs, connect PCMHs to their medical-health neighborhood, and implement population health projects.

¹ Per page 160 of Idaho’s *AY3 Operational Plan*: The medical-health neighborhood is “... the clinical-community partnership that includes the medical, social, and public health entities that provide wrap-around supports for the PCMH and patient to achieve better health outcomes and wellness. The medical-health neighborhood can include medical specialists; community services such as food, housing, and transportation; dietitians; behavioral health specialists; home health; dental professionals; CHWs; CHEMS; education; social services; etc.”

Figure D-1. Timeline of Idaho State Innovation Model and State Innovation Model-related activities



D-3

CEMS = community health emergency medical services; CHW = community health worker; ECHO = Extension for Community Healthcare Outcomes; HIE = health information exchange; IHC = Idaho Healthcare Coalition; PCMH = patient-centered medical home; PMPM = per member per month; SHIP = Statewide Healthcare Innovation Plan; TA = technical assistance.

Notes: Lighter shades (with ¹) of the same color bars denote similar activities or models. Gray bar (with [^]) denotes that the item is not a SIM activity or policy but is important for context.

Idaho also has implemented complementary strategies to provide data for care coordination and performance improvement and to create new types of workers to extend the reach of existing PCPs into rural areas and better support care coordination. Finally, the SIM Initiative seeks to increase the use of VBP among payers and providers.

State officials, providers, and other stakeholders viewed the SIM Initiative as an opportunity to improve primary care and implement payment reform. In a state political context that values fostering consensus among stakeholders rather than government-driven efforts, the SIM Initiative, with the Governor's support, developed a flexible public/private partnership approach to improving the state's health care delivery system. The Office of Healthcare Policy Initiatives in the Idaho Department of Health and Welfare (IDHW) oversees the SIM Initiative. The IHC, which comprises key stakeholders from both the private and public sectors and is co-chaired by a representative of each sector, was established by executive order in February 2014 to guide SIM implementation.

By the end of the AR2 analysis period, the SIM Initiative had successfully engaged providers in the state to participate in PCMH transformation, building on pre-SIM provider interest in the model. Eighty-one clinics applied for 56 PCMH openings in Cohort 2, and as of December 2016, 32 of the clinics in Cohort 1 had achieved PCMH certification. Only six clinics had been recognized as virtual PCMHs. As reported in the SIM2 AR2,² interviewees believed that lack of payment for CHW services and CHEMS had hampered the efforts of cohort clinics to become virtual PCMHs.³

The state faced two other main challenges: delays in connecting PCMHs to the IHDE, and payment reform. Whereas Medicaid implemented the per member per month (PMPM) model promoted by the SIM Initiative, commercial payers resisted. In response, SIM staff continued to support private payers pursuing other forms of VBP by convening a multi-payer work group and facilitating information sharing about VBP.

² CMS. (2018). *State Innovation Models (SIM) Round 2: Model Test Annual Report Two*. Retrieved from <https://downloads.cms.gov/files/cmimi/sim-round2test-secondannrpt.pdf>

³ To become a virtual PCMH, a clinic must participate in one of the three cohorts and incorporate at least one of the following three components into its practice: telehealth, CHWs, or CHEMS.

D.2 Progress and Accomplishments from Idaho’s State Innovation Model Initiative, May 2017–March 2018

D.2.1 Delivery models and payment reforms

Key Results
<ul style="list-style-type: none">• The third and final PCMH cohort launched with 54 clinics.• The state recognized 28 virtual PCMHs, an increase from 6 virtual PCMHs in the previous year.• Medicaid developed plans to launch three new VBP models, two of which were based in PCMHs.

The SIM Initiative’s goal is to transform its delivery system into one based in PCMHs operating within a medical-health neighborhood—leading the state’s delivery system and payment reforms to center on supporting the PCMH model. The SIM Initiative convened three cohorts of clinics in sequence, with each cohort receiving a program of support that included financial and technical assistance (TA). The TA consists of individual practice coaching, Webinars, and in-person meetings (see *Section D.2.3*). Each clinic also receives a bidirectional connection to the IHDE and up to \$17,500 in reimbursements for transformation costs. Reimbursement is available to practices that achieve specific milestones: up to \$10,000 for PCMH transformation, \$5,000 for national PCMH recognition, and \$2,500 for becoming a virtual PCMH. The Idaho SIM Initiative also created virtual PCMHs to extend existing primary care resources in underserved and rural areas. *Table D-1* summarizes the state’s progress on delivery system and payment reforms.

The SIM Initiative continued working to establish the PCMH model as the foundation of the state’s health care delivery system. In February 2018, Idaho launched its third and final cohort of clinics seeking to transform into PCMHs or advance their PCMH capabilities. Cohort 1 (55 clinics) concluded its year of assistance in January 2017, Cohort 2 (56 clinics) concluded its year in January 2018, and the final cohort of 54 clinics began their transformation work in February 2018.

The IDHW’s work with Cohorts 1 and 2 revealed that it took most clinics longer than a year to secure national PCMH recognition. This finding led the IDHW to consider modifying the requirements for reimbursement for the cost of achieving that milestone, so that Cohort 3 members would be able access SIM financial assistance before the SIM Initiative’s conclusion in 2019. During the AR3 analysis period, staff also established a peer mentorship program to enable PCMHs to continue to work together to transform their practices after the end of the SIM award.

Table D-1. Idaho’s progress on delivery system and payment reforms

Activity	Target population	Key activities	Progress between May 1, 2017, and March 31, 2018
PCMH	Primary care clinics and their patients	Providing reimbursement and TA to three cohorts of clinics seeking to become PCMHs or improve PCMH performance	<ul style="list-style-type: none"> • Cohort 2 completed the PCMH assistance program. • Cohort 3 launched. • Peer mentorship program for PCMHs was established.
Virtual PCMH	PCMHs in rural and underserved areas and their patients	Recognizing PCMH clinics that implement specified functions that extend their ability to serve patients in rural and underserved areas	<ul style="list-style-type: none"> • Increased the number of recognized virtual PCMHs from 6 to 28.
PCMH payment models	PCMHs and their patients	Fostering implementation and spread of payment models that support PCMHs	<ul style="list-style-type: none"> • Medicaid began planning two new payment models based in the PCMH program, both featuring shared savings with some PCMHs. • Commercial payers continued participation in the IHC and showed increased interest in aligning measures used in payment models.

IHC = Idaho Healthcare Coalition; PCMH = patient-centered medical home; TA = technical assistance.

Interviewees cited the SIM Initiative’s work to spread the PCMH model as a major success. Interviewees pointed to the SIM Initiative’s ability to meet the goal of recruiting 165 clinics to participate in PCMH transformation as evidence of this success. Medicaid representatives and some commercial payers reported that cohort participation helped clinics prepare for VBP. Others pointed to external recognition (NCQA and Medicaid) of the clinics’ PCMH capabilities as an indicator of success. State officials reported that as of March 2018, 64 of the 111 clinics from Cohorts 1 and 2 had achieved national PCMH recognition as a PCMH, including 10 that received recognition for the first time during the AR3 analysis period. As of March 2018, 74 clinics from the first two cohorts had qualified for higher PMPM payments from Idaho Medicaid’s Healthy Connections program because of improvements in care delivery.⁴

Idaho increased the number of virtual PCMHs. Idaho set an interim goal of 30 virtual PCMHs by January 2018 and 50 virtual PCMHs by the end of the SIM Initiative in 2019. State

⁴ As described in previous reports, Idaho Medicaid implemented a four-tier, PMPM payment for PCMH activities, effective February 1, 2016. PCMHs qualify for higher payments by meeting higher standards and moving up in tiers. For example, to qualify for the highest payments, a practice must conduct QI, including performance measurement—a core element of the assistance provided by the SIM Initiative. PMPM payments ranged from \$2.50 to \$10, depending on the tier.

officials reported they had recognized 28 virtual PCMHs by January 2018.⁵ Although the SIM Initiative did not meet its interim goal, state officials noted that 28 virtual PCMHs was a significant increase over the 6 that were recognized as of March 2017. Interviewees credited this increase to greater awareness of the opportunity and a larger pool of potential applicants as Cohort 2 members became eligible for this recognition. Most state officials were optimistic that they would achieve the goal of 50 by January 31, 2019, especially because Cohort 3 participants would become eligible for virtual PCMH recognition in July 2018. Some stakeholders, however, were concerned that the SIM Initiative might not meet this goal, because of the many other draws on clinics' time, including establishing the IHDE connection and integrating HIE use into work flows.

Progress continued in Medicaid payment reform. As reported in AR2, stakeholders originally had hoped that all payers would adopt a payment model consisting of fee for service (FFS) plus a PMPM payment for PCMH activities. The Medicaid agency adopted this payment model in 2016, but no other payer has done so. Medicaid is now developing three new VBP models (*Table D-2*). Two of these models (regional care organizations [RCOs] and PCMH Shared Savings) include primary care and build on the PCMH model. Medicaid beneficiaries will be attributed to the models based on their PCMH's choice of model. Although the planned episode of care model does not include primary care, this model would help organize the medical-health neighborhoods within which PCMHs operate. Implementation of the three new Medicaid models is planned for July 2018, although some interviewees stated that implementation might be delayed.

Some interviewees believed these new models could produce substantial payments to high performing, efficient PCMHs that would provide financial sustainability and support the spread of the PCMH model. The TA provided to clinics participating in the cohorts was modified to prepare the clinics for the new payment models, by helping the clinics better understand the models and how they might support PCMH activities.

"I think we definitely have to dial down FFS and definitely dial up quality and shared savings and PMPM. ... We need to make these changes so that providers like me can figure out how to use financial resources to deliver the type of care I want to the community."

—Provider

⁵ Idaho progress report metrics, Award Year 3, Report 4.

Table D-2. New Medicaid value-based payment models

Model	Contracted providers	Targeted services	Payment
RCOs	<ul style="list-style-type: none"> State to be divided into 3–5 regions Medicaid to contract with 1 RCO in each region RCOs will include physicians and hospitals RCOs required to include a CHOICE 	Most Medicaid services	<ul style="list-style-type: none"> FFS for Medicaid-covered services PMPM for PCMH activities Shared savings paid if quality benchmarks met CHOICE-recommended community investments of shared savings that exceed a predetermined amount
PCMH Shared Savings	PCPs throughout the state	Primary care delivered within a medical-health neighborhood	<ul style="list-style-type: none"> FFS for Medicaid-covered services PMPM for PCMH activities Shared savings for Tier 3 or 4 PCMHs if quality benchmarks met
EOCs	Specialists throughout the state	Episodic clinical care, such as some surgeries	<ul style="list-style-type: none"> FFS for Medicaid-covered services Shared savings if quality benchmarks met

Source: Healthy Connections Value Care White Paper, Version 5.⁶

CHOICE = Community Health Outcome Improvement Coalition; EOC = episode of care; FFS = fee for service; PCMH = person-centered medical home; PCP = primary care provider; PMPM = per member per month; RCO = regional care organization.

Although payment reform among commercial payers was an ongoing challenge for the SIM Initiative, commercial payers became more engaged. Commercial payers had been unwilling to adopt the FFS plus PMPM payment model put forward by the SIM Initiative, preferring to pursue their own payment models. Stakeholders interviewed continued to report commercial payer payment reform as a challenge, but they also reported progress because of the greater engagement of commercial payers in the IHC. Some pointed to the growing understanding of how payment models that shared both risk and savings among payers and providers could benefit PCMHs. Others pointed to payers’ growing recognition that alignment on some aspects of payment, especially the performance measures that they factor into VBP, could benefit them. Still other stakeholders credited greater engagement of commercial payers in part to leadership changes at one of the plans.

⁶ IDHW. (2017, September). *Idaho Medicaid—healthy connections value care white paper, Version 5*. Retrieved April 24, 2018, from <https://healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/Healthy%20Connections/HCValueCareWhitePaper.pdf>

Interviewees reported that increased payer engagement already had produced positive outcomes. As of the AR2 analysis period, providers believed most payers did not cover telehealth services. However, payers interviewed during the AR3 analysis period said this was a misperception, which the multi-payer workgroup of the IHC was working to correct through development of a matrix summarizing all payers' telehealth coverage policies.⁷ This matrix was described as helpful to the SIM Initiative's efforts to promote telehealth, which include establishing telehealth as a component of virtual PCMHs.

Sustainability

Idaho's work on sustainability was still in its early stages, but there was strong support for sustaining both PCMH transformation and the payment reform work. The SIM Initiative

convened a PCMH sustainability workshop in January 2018 and surveyed IHC members in early 2018. One theme that emerged from those efforts was strong support for continuing to work on payment reform after the SIM Initiative ends. Many

interviewees expressed the belief the clinics that participated in the three cohorts would be able to sustain the changes they had made to care delivery. These interviewees were especially optimistic that Medicaid's payment reforms (the four-tier PMPM payment model implemented in 2016 and the two new PCMH-based payment models in planning stages) would provide enough support to maintain the transformations and encourage other providers to become PCMHs.

"[There is] not enough time and, frankly from our starting point, we were not at a level that was in line with the rest of the nation for even monitoring APM [alternative payment model] and payments. I mean this was starting from the ground and building up."

—State official

Interviewees were less confident that CHW services and CHEMS would be sustained without further payment reforms. Some interviewees believed that practices would be able to fund the staff with shared savings generated under the new Medicaid payment model. Additionally, although payers remained uninterested in recognizing CHW services and CHEMS as new benefits eligible for FFS reimbursement, state officials had discussed with some payers the potential of other payment arrangements, such as an administrative contract. Interviewees believed payers were open to paying for these services, if a business case could be made.

"We'd be very interested in programs like that [CHEMS]. ... But to move forward I would need a cost proposal for the services ... so that we could do an ROI [return on investment], which is what we do with any other third-party vendor that we hire to go take care of patients in their home."

—Payer

⁷ IHC. (2018, May 9). *Idaho Healthcare Coalition meeting topics and discussions* (p. 7). Retrieved from <https://ship.idaho.gov/Portals/93/Documents/IHC/2018/MayIHCAttachments.pdf?ver=2018-05-08-164456-953>

D.2.2 Progress toward a preponderance of care in value-based payment and alternative payment models

Key Results

- Stakeholder opinions varied on Idaho’s ability to reach 80 percent preponderance of care.
- Commercial payers reported developing VBP arrangements and strategies to engage with more providers.
- Medicare and commercial payers reported an increase in the percentages of payments linked to quality.

Opinions ranged widely about whether Idaho could move 80 percent of the state’s population into VBP or an APM by the end of the SIM Initiative in 2019. Most stakeholders believed Idaho was progressing toward 80 percent but that the goal would not be reached during the SIM Initiative. Even stakeholders who believed a preponderance of care could be reached felt that achievement of the goal depends on which payments, populations, or providers would be included in the preponderance-of-care calculation.

One interviewee noted a challenge in reaching a preponderance of care using a payment-based definition because inpatient hospital services comprised such a large percentage of payments, and those services were not included in Idaho’s VBP model. Another interviewee suggested attribution would pose a problem in calculating preponderance of care because many members of commercial insurance plans never saw a doctor during the year, preventing them from being attributed to primary care practices. Several interviewees indicated they would like more guidance about how the measure would be defined and calculated. Participating commercial payers had begun to report data on VBP model participation nonetheless, and interviewees seemed optimistic that progress was being made on VBP model participation.

“One of the scorecards we track in our company is the number of dollars flowing through value-based ... it’s an absolutely enormous issue for us. And we’ve invested enormous dollars in it. ... So, I think we can get there, yeah, because I think the commercial payers are driving it, and I’m glad that Medicaid is moving in the direction that they are.”

—Commercial payer

Idaho did not use regulation to require participation in the SIM Initiative but instead relied on collaboration and information sharing to incentivize payers. Whereas Idaho prides itself on using “carrots and not sticks,” several stakeholders pointed out this approach might have negatively impacted model participation. One stakeholder suggested that reaching 80 percent of the population would be a challenge, because many people were covered by plans that were not engaged in the SIM Initiative and had not adopted VBP, including Idaho’s sizable self-funded insurance population.

Commercial payers and Medicaid reported they were working to develop and expand VBP, thereby enabling them to include more providers and beneficiaries in VBP models.

One large commercial payer said the organization had extended the opportunity for shared savings to independent rural physicians by aggregating their attributed patients and performance, thus enabling them to pass the threshold for participation. Another payer was planning to adopt a similar mechanism and had set a goal of paying 80 percent of all claims through value-based arrangements by 2020. A third commercial payer indicated commitment to collaborating with all providers to bring them further along the VBP continuum. As described in *Section D.2.1*, Medicaid was developing new payment models to bring more beneficiaries, providers, and payments under VBP models. Some interviewees seemed optimistic that VBP models that support PCMHs would be incorporated into the state employee health coverage contract, which was set to be re-procured after the SIM award ends in 2019. Previously, Idaho’s constitutional limits on the ability of the state to accept financial risk had constrained Idaho’s ability to innovate with state employee health care coverage. However, the Idaho legislature formed the State Employee Group Insurance & Benefits Committee in February 2018 to study the state employee group insurance plan structure and make recommendations. State officials believed the PCMH model could be included in the committee’s recommendations.

“Our goal is to hit 80 percent of all claims through value-based care by 2020. We hit a little over 50 percent in 2017. By the end of this year we need to hit 60 percent, and then 80 percent by 2020.”

—Commercial payer

Idaho used an independent contractor to collect data on payment models to address commercial payer concerns about releasing proprietary information.

The contractor entered into confidentiality agreements with all payers to ensure their data were kept secure and private. All but one commercial payer reported their percentages of beneficiaries and of payments in the Learning and Action Network categories. Despite the progress in obtaining commercial payer cooperation with reporting preponderance-of-care metrics, some payer concerns remained that the level of detail requested on APMs had the potential to undermine competitive strategies.

“But for us to disclose how those value-based arrangements work, we would say no thank you. We have to be able to make sure we can use that as a competitive advantage where it exists.”

—Commercial payer

Table D-3 shows that 24.6 percent of the state population were in primary care PCMHs in Award Year (AY) 3, as reported in Idaho’s AY3, Report 4 progress report to CMMI.⁸ This is the only SIM payment model in the state. No data were provided about alternative payment or health care delivery models outside the SIM Initiative, and no payer-specific data were reported. Idaho also did not report on the extent to which payers were participating in the SIM payment and health care delivery models.

Table D-3. Populations reached by a value-based payment or alternative payment model in Idaho, latest reported figures as of Award Year 3, Report 4

Payer type	SIM models			Landscape
	PCMHs	Other ¹	SIM Initiative-wide	Any VBP or APMs
Statewide	402,645 (24.6%)	—	402,645 (24.6%)	—

Source: Idaho SIM Initiative Award Year 3, Report 4 Metric Template.

— = relevant data not provided in the data source; APM = alternative payment model; PCMH = patient-centered medical home; SIM = State Innovation Model; VBP = value-based payment.

¹ “Other” is for the virtual PCMH model, which is a subset of the reported primary care PCMHs, and a designation only PCMHs participating in the SIM Initiative can attain.

Note: The denominator is the total state population (1.634 million).

As of fourth quarter 2017, Medicare had the largest percentage of beneficiaries under VBP arrangements (*Table D-4*). Less than half of Medicare payments were Category 1 FFS payments, with more than one third in Category 2 and almost one fifth in Category 3. Although more than two thirds of commercial insurance and Medicare Advantage payments remained in Category 1, four percent were in Category 4 population-based payments. Medicaid had made the least progress toward moving expenditures into more VBP methods, with nearly all payments still Category 1 FFS payments.

By the end of 2017, before Cohort 3 clinics joined, 111 provider organizations participated in a SIM cohort to develop as, or transform into, a PCMH (*Table D-5*). Approximately six percent of provider organizations were designated as virtual PCMHs, a designation that only SIM-participating practices could obtain. The state did not report data about provider organization participation in VBP and APM or health care delivery models outside the SIM Initiative. The state also did not report any information about provider participation.

⁸ Because these data were not verified by CMMI, the RTI team cannot attest to their accuracy.

Table D-4. Payers participating in a value-based payment or alternative payment model in Idaho, latest reported figures as of Award Year 2

Payer	Category 1 Payment: FFS with no link of payment to quality		Category 2 Payment: Payment linked to quality		Category 3 Payment: APMs		Category 4 Payment: Population-based payment	
	Number of beneficiaries	Percentage of payments	Number of beneficiaries	Percentage of payments	Number of beneficiaries	Percentage of payments	Number of beneficiaries	Percentage of payments
Commercial & Medicare Advantage	115,933	68%	370,541	19%	23,375	9%	10,269	4%
Medicare	19,429	45%	213,893	37%	39,154	18%	0	0%
Medicaid	44,587	99%	298,392	1%	0	0%	0	0%

Source: Idaho SIM Initiative Award Year 3, Report 4 Metric Template.

APM = alternative payment model; FFS = fee for service; SIM = State Innovation Model.

Table D-5. Providers participating in a value-based payment or alternative payment model in Idaho, latest reported figures as of Award Year 3, Report 4

Provider type	SIM models			Landscape
	PCMHs	Other ¹	SIM Initiative-wide	Any VBP or APMs
Provider organizations	111 (22.2%)	28 (5.6%)	111 (22.2%)	—

Source: Idaho SIM Initiative Award Year 3, Report 4 Metric Template.

— = relevant data not provided in the data source; APM = alternative payment model; PCMH = patient-centered medical home; SIM = State Innovation Model; VBP = value-based payment.

¹ “Other” is for practices designated as a virtual PCMH. Only PCMHs participating in the SIM Initiative can be designated as a virtual PCMH, so the number of virtual PCMH practices is a subset of the reported primary care PCMHs.

Note: The denominator is an estimate of the total primary care clinics in Idaho (500).

D.2.3 Enabling strategies to support health care delivery transformation

Key Results
<ul style="list-style-type: none"> • TA and other support facilitated clinics’ practice transformation efforts, enabling the state to achieve the goal of engaging 165 clinics. • A peer mentorship program was established that offers potential for continued clinic support after the SIM Initiative ends. • Telehealth and CEMS programs were on track to achieve their goals, but Idaho may not meet its goal of training 125 CHWs. • Connecting clinics to the IHDE remained challenging and delayed the implementation of the statewide data analytics system; however, the state, working with the IHDE, made considerable improvements in this area.

The enabling strategies the SIM Initiative used to support delivery system and payment reform include providing TA to support practice transformation, enhancing health workforce capacity in rural areas, and establishing health information technology (health IT) and quality measurement infrastructure (*Table D-6*).

Table D-6. Idaho’s progress on enabling strategies to support health care delivery transformation

Activity	Target population	Key activities	Progress between May 1, 2017, and March 31, 2018
Practice transformation	PCMH clinics	TA and individualized coaching	• 72 clinics achieved national PCMH recognition by January 2018; the state met its goal of engaging 165 clinics.
Workforce development	PCMH clinics, community emergency medical services agencies, individuals receiving CHW training	Training for CHW and CEMS programs; establishing telehealth in rural clinics	• 10 CEMS programs were established, 23 community paramedics trained, 49 CHWs trained, and 12 telehealth sites established.
Health IT and data infrastructure	PCMH clinics	Connecting PCMH clinics to the IHDE	• Bidirectional connections were established for 37 (of 55) Cohort 1 clinics and 32 (of 56) Cohort 2 clinics.
Measure alignment	PCMH clinics and their patients	Producing reports from data supplied by the IHDE showing PCMH performance on 16 clinical quality measures	• Operationalized six more of the 16 measures, so the statewide data analytics contractor can produce a total of 10 measures once data quality sufficiently improves.

CEMS = community health emergency medical services; CHW = community health worker; health IT = health information technology; IHDE = Idaho Health Data Exchange; PCMH = patient-centered medical home; TA = technical assistance.

Practice transformation

Idaho’s SIM Initiative supported clinics’ PCMH transformation efforts by providing them with direct TA through learning collaboratives, Webinars, clinic mentoring, and individualized coaching. Additionally, RC staff⁹ engaged clinics directly to help facilitate practice transformation and offer clinics opportunities to connect with the broader medical-health neighborhood in their respective regions. Medicaid Healthy Connections staff also helped clinics ensure that their transformation efforts through the SIM Initiative align with the requirements of Medicaid payment tier advancement.

⁹ We use “RC staff” to refer to staff hired by each Public Health District to support its RC. In supporting the RCs’ work, IDHW has contracts with the Public Health District via a subgrant to fund three RC staff in each district: a SIM Initiative manager, a QI specialist, and an administrative assistant.

The state’s practice transformation activities progressed well through efforts by the clinics, the RCs, a peer mentorship program, and support from TA providers. Although there were some challenges with Cohort 3 recruitment in fall 2017, and only 58 applications were received, the state enrolled 54 clinics—meeting its overall goal of engaging 165 clinics in the three cohorts. As of mid-January 2018, 72 clinics had achieved national PCMH recognition. The Cohort 3 clinics included some that were less familiar with the PCMH model—only 7 percent began with national PCMH recognition, compared with 49 percent in Cohorts 1 and 2. Cohort 3 clinics were also more likely to be independent, private practices and less likely to be owned by a hospital or health system or be a Federally Qualified Health Center (FQHC) or community health center. As a result, they were more likely to have limited internal resources for practice transformation and face greater challenges in coordinating care. State officials were anticipating that practice transformation for this cohort could be challenging because, compared with the previous two cohorts, participating clinics were less acquainted with the PCMH model and would have the shortest period to transform their practices before the end of the SIM Initiative.

Interviewees commented positively on cohort clinics’ efforts to transform care delivery, although some clinics were transforming faster than others. Interviewees noted that some of the clinics in the first two cohorts transformed faster because they were already pursuing PCMH transformation, already nationally accredited, or part of larger health systems with greater capacity to implement transformation efforts. Clinics that were already nationally accredited focused on becoming higher-performing PCMHs. Interviewees reported that all clinics were actively engaged in practice transformation by changing clinic processes, hiring new staff (e.g., different types of care providers), and adding QI projects. Additionally, many clinics closely assessed their teams and modified staff roles to ensure their personnel were working at their licensure capacity, tasks were appropriately delegated, and staffing models supported care coordination activities.

Most interviewees reported that the TA provided to clinics to support practice transformation was useful, although its effectiveness might depend on clinics’ readiness to transform. The RC staff assisted with practice transformation efforts by helping to coordinate TA activities through the role of the public health district QI specialist, facilitating connections to the medical-health neighborhood, and promoting informal clinic mentoring. One state official commented that the QI staff person hired to support each RC worked directly with the clinics, was key in assisting clinics with PCMH transformation efforts and that ideally, these positions would be maintained after the SIM Initiative ends. However, one interviewee reported

“Hiring the QI specialists was a really great opportunity for the health districts, and I know through the reports from PCMHs, they really value the local QI specialists coming in. So, if there’s something to preserve, it would be maintaining that position at the health district.”

—State official

that practices had a range of views on the effectiveness of the coaching. Although some clinics indicated the coaching has been invaluable, others found it less helpful, according to the interviewee, perhaps because the clinic itself was not prepared to implement the recommended changes.

An important accomplishment during the AR3 analysis period was the establishment of a peer mentorship program among the cohort clinics to provide ongoing practice transformation support. Stakeholders viewed the mentorship program as an extension of the work of the learning collaboratives, the informal mentoring occurring naturally through the RCs, and a possible way to sustain clinic support after the SIM Initiative ends. The mentorship program began in May 2017 with meetings to develop a framework of activities to support clinics. These activities included a Webinar series on topics such as care coordination and an in-person panel discussion featuring clinic support staff perspectives on PCMH implementation. One state official described significant interest and participation in these optional mentorship Webinars and said clinics were very willing to serve as mentors. State officials also were planning to survey cohort clinics to help identify topic areas and issues on which they could mentor other cohort clinics. To complement the mentorship activities, the SIM Initiative was developing an online resource guide to be available later in 2018, which will include recordings of the Webinars and the in-person panel discussion.

Improved relationships between stakeholders and more tailored TA further facilitated practice transformation. Over the AR3 analysis period, relationships between the public health district staff and the contracted TA coaches strengthened, and roles became more clearly defined. Furthermore, the SIM Initiative was able to provide clinics with better targeted assistance by working with the contractors to develop TA toolkits on such topics as managing staff turnover. Idaho also added user-friendly enhancements to the portal for clinics, such as a calendar feature to track appointments, improved ways to save information, and a discussion forum feature, which increased the use of the portal.

Workforce development

To help address Idaho's health and behavioral health workforce shortages and improve rural residents' access to care, another SIM goal was to promote telehealth, train CHWs, and implement CHEMS programs.

Stakeholders commented that the state made notable progress on further implementing telehealth. Twelve telehealth sites were established, and state officials were pleased with the TA for telehealth provided by their contractor, which included individual site visits to assist clinics in establishing and building their programs, monthly calls, and an upcoming telehealth learning collaborative to focus on reimbursement issues. Additionally, the state used some of the funding remaining from the telehealth goal to begin to implement a

Project ECHO (Extension for Community Healthcare Outcomes)¹⁰ hub model. A new initiative for the state, this project is to initially focus on opioid addiction and treatment and later, on behavioral health in primary care.

The state was on track to achieve its goal of establishing 13 CHEMS programs by the end of the SIM award in January 2019 but behind in progressing toward the aim of training 125 CHWs. As of March 2018, 10 CHEMS programs were established, 23 community paramedics were trained, and 49 CHWs were trained and working in clinics and/or communities. During AY3, the CHWs that received training contacted 6,914 patients, served 2,763 unique patients, and conducted 403 outreach or enrollment events.¹¹ The state adapted the CHW training curriculum from Massachusetts with SIM funding and engaged universities and other entities to facilitate program implementation. State officials commented that, in retrospect, the CHW program should have been designed to provide students with full certification, which would allow for greater reimbursement opportunities, rather than only a certificate of completion—although implementing a program that offered full certification would likely not have been feasible within the SIM Initiative time frame. State officials highlighted that a CHW association—which operated in partnership with the heart disease, diabetes, and stroke prevention program in the public health department—could explore future options for certification and reimbursement. For CHEMS, in addition to the community paramedic programs, plans were under way to provide CHEMS training to emergency medical technicians, which would be the first program of its kind in the United States.

Many interviewees identified lack of reimbursement to cover the cost of incorporating CHWs and CHEMS into provider practice workflows as a significant challenge to the growth of these models.

However, as mentioned in *Section D.2.1*, state officials reported feeling more optimistic about potential financing for these programs, based on conversations over the past year with some payers. State officials expressed hope that both the CHEMS and CHW programs would continue in some form after the SIM Initiative ends, not only because of the momentum and support for these efforts but also because they might fit well with the planned Medicaid RCOs.

“... that issue of reimbursement is a significant challenge for those two programs [CHW and CHEMS]. As far as advances in this area, I feel more optimistic than a year ago when it seemed nothing was happening in that arena.”
—State official

¹⁰ Project ECHO is a collaborative medical education and care management model that increases access to specialty treatment in rural and underserved areas by linking primary care clinicians in those regions to expert specialists at academic hubs through teleconferencing technology.

¹¹ From the Statewide Healthcare Innovation Plan Operations and IHC Workgroup Report to the Idaho Healthcare Coalition, March 14, 2018.

Health information technology and data infrastructure

Through the SIM Initiative, Idaho envisioned using health IT to provide PCMHs with information to facilitate individual-level care coordination and share data more broadly about PCMH performance on certain clinical quality measures. The IDHW contracted primarily with the IHDE to facilitate these connections and information sharing.

Interviewees noted that the IHDE made significant progress in connecting clinics and enhancing its HIE capabilities. Interviewees attributed these positive changes in large part to the hiring of a new executive director for the IHDE in August 2017, which made a significant difference in several ways. In addition to bringing the necessary

professional expertise to the position, the new director hired staff members with the appropriate skill sets and added new positions, such as a project manager to oversee implementation of the contract deliverables and provide overall project management support. In coordination with the IDHW, the IHDE also developed a corrective action plan to address challenges, which is scheduled to continue to be implemented in the final award year of the SIM Initiative. One interviewee cited the guidance of the Data Governance Workgroup, a data oversight committee created in May 2017, as very helpful to both the IHDE and statewide data analytic system work. Another significant accomplishment over the AR3 analysis period was the procurement of a contract to implement a new IHDE platform. The current platform is not adequate for the state's growing needs, with such limitations as not being able to accept claims data from payers. With a new vendor contract signed in late 2017, the IHDE was expected eventually to have a more robust platform with additional interface capabilities.

"We've done quite a lot with the health data exchange, there's been more of a collaborative relationship ... and we've been able to connect more practices, and so that's a big accomplishment."

—State official

Interviewees commented that, although the health IT and HIE work progressed, the state was still behind in its original goal for connecting clinics to the IHDE, and challenges remained. Connecting cohort clinics to the IHDE continued to prove more challenging than anticipated, which delayed the implementation of the statewide data analytics system. As of December 31, 2017, bidirectional connections had been established for 37 of the 55 Cohort 1 clinics and 32 of the 56 Cohort 2 clinics; work was in progress to connect Cohort 3 clinics and the remaining Cohort 1 and 2 clinics. Interviewees expressed mixed views about whether all cohort clinics would be connected by the end of the SIM Initiative award period, recognizing that the many different electronic health records (EHRs) used in the state increased the complexity of the task. Other barriers to establishing connections between clinics and the IHDE included issues with legal agreements and costly EHR maintenance fees. Developing bidirectional clinic connections was also important to many providers, because doing so was a requirement to advance to the highest tier in the Medicaid Healthy Connections program. The state legislature, however, did not fund a Medicaid Supplemental budget request to support clinic connections. In

response, the Medicaid agency began looking for other ways to finance the connections within its current budget, and the IDHW also planned to continue to leverage Health Information Technology for Economic and Clinical Health (HITECH) funding to support these efforts.

Interviewees identified the implementation of data QI efforts as another notable accomplishment but said further refinement of the quality of the data analytics reports was needed. Although the state intended for reports based on information contained in the IHDE to provide clinics with actionable data, the initial versions of these reports had many data gaps and significant quality issues. To address these problems, the state used SIM Initiative funding to hire a data quality specialist at the IHDE, who worked closely with the data analytics contractor and directly with the clinics to identify where the data issues were occurring. Although progress was made, and most interviewees reported feeling optimistic that there was a data QI process in place, they acknowledged that it would take some time before accurate data analytic reports could be produced. The data cleaning process is time consuming, because it involves working with clinics individually and going through each data element at different points in the data flow.

Interviewees reported that some clinics were beginning to use IHDE data for care coordination. However, its effectiveness depended on whether the local hospitals were also connected to the IHDE, which varied by region. Additionally, some providers commented that, while they received clinical data that could be helpful, the reports might not identify patients correctly or contain superfluous information about individuals not among their patients. Furthermore, finding the relevant patient information in the reports could be challenging, because of the inclusion of unnecessary data and the large quantity of documentation needed for liability protection.

Quality measurement alignment

The SIM Initiative sought to align quality measures from its inception. Idaho envisioned a statewide data reporting system that would draw on IHDE data to produce measures of PCMH performance across payers and at the clinic, regional, system, and statewide levels. Idaho's plans did not call for these measures to immediately replace those already in use. Rather, the state considered the measures to be a new source of cross-payer performance information that could be used in conjunction with other measures—and, perhaps, gradually replace some of those other measures.

Idaho operationalized six new clinical quality measures within the statewide reporting system. Idaho planned to produce reports by the end of its SIM Initiative to show clinic performance on 16 clinical quality measures at the clinic, regional, and statewide levels, based on data extracted from the IHDE. The measure specifications were to be developed and operationalized over time: four were operationalized in August 2016 and six in November 2017. The final six were to be operationalized in July 2018. However, as described in more detail

below, operationalizing the measures confirmed that there were extensive problems with the quality of the data used to generate the measures.

Delays in connecting clinics to the IHDE and issues with data quality prevented production of any actionable reports on quality measures. Although three interviewees reported that improvements in data quality and analytics were a significant accomplishment, most interviewees were not confident that the SIM Initiative would be able to produce actionable reports at the clinic, regional, and statewide levels by the end of the SIM award on January 31, 2019. A few respondents, however, were optimistic that such reports could be produced for some clinics. All interviewees agreed that data and measurement remained a significant challenge, with at least two stating that the SIM Initiative needed to revisit the goals it had established in this area. Several explained that lack of data standardization across the variety of EHRs in use in Idaho was a major impediment to quality measure reporting. As an example, different EHRs stored body mass index in different places in the files transmitted to the IHDE.

Although lack of actionable reports based on IHDE data was viewed as a major challenge, clinics and RCs moved ahead using each clinic’s own medical record data. For example, clinics belonging to one hospital system produced and validated four quality measures each month. The clinics then shared the results at staff meetings, with awards going to clinics with the best scores in each category. The system reported improvement in measures received from the clinics. Similarly, one RC asked clinics to produce and validate specified quality measures each quarter. The RC then collected the results from the clinics and used them to foster discussion among the clinics at the RC meetings.

Several interviewees, including payers, expressed strong interest in aligning the measures used in VBP across payers. These payers viewed the multi-payer workgroup of the IHC as an appropriate group to lead that effort. This view contrasts with the interviews conducted in March 2017, in which payers expressed little interest in measure alignment. Payers were specifically interested in an approach that facilitates, but does not require, alignment—an approach developed by workgroup members representing the major commercial plans in Idaho. These payers were considering developing a menu of measures each payer could produce from its own data. For example, if a payer were interested in establishing an incentive for diabetic care, the payer could draw relevant measures from the menu, add other measures, and then use its own methods to establish a benchmark for performance.

“If we say, for example with diabetes, here’s a standard way of doing it, but it’s not a requirement, then we [payers] could agree with that. ... But there wouldn’t be any requirement that you would have to use those measures, it would just be a menu of options, and so if you decide to do one thing, here some are guidelines we hope you would use.”

—Payer

Sustainability

As of March 2018, the state was in the process of determining how to continue to support strategies to enable practice transformation in the future. The IDHW promoted peer mentoring and was in the process of assessing options for maintaining other practice-level supports and resources to support continued practice transformation. At the January 2018 PCMH sustainability workshop, participants developed a goal of doubling the number of PCMH-recognized practices by 2024. Additionally, the state planned to continue supporting CHWs, CHEMS, and telehealth through Project ECHO, and training for CHWs and CHEMS through Idaho State University after SIM funding ended. The state also intended to build on the data exchange and analytic work conducted through the SIM Initiative and to have the IHDE continue to work with clinics and hospitals to maintain and establish new connections. Additionally, the IHDE’s new platform to be implemented in 2019 was anticipated to be able to accept claims data and provide improved data analytics to providers.

D.2.4 Population health

Key Results
<ul style="list-style-type: none"> • Population health activities were largely unchanged from the previous year. • The IHDE’s delays hampered population health efforts. • Options for post-SIM sustainability of RCs varied by region.

In addition to their role supporting clinics in PCMH transformation efforts (described in *Section D.2.3*), RCs are expected to identify and address local population health needs, develop a local medical-health neighborhood, and foster connections between clinics and the neighborhood.

RCs continued their work during the AR3 analysis period, but population health activities were mainly unchanged from the previous year. A state official noted that RCs were more focused on their role in supporting PCMH transformation than on population health, although RCs continued building partnerships with medical neighborhood service providers. One RC established a subgroup of clinics working to integrate PCMHs into the neighborhood, identifying gaps in services, and sharing information about effective ways to achieve better connections across services. Another held quarterly meetings that brought together clinics, academic institutions, social services, transportation providers, local food banks, and other community organizations. One RC purchased a suicide prevention toolkit, which was shared with clinics across the state. An interviewee noted that RCs shared information about their activities with one another, which helped further disseminate ideas.

RCs varied in their effectiveness. One interviewee observed that the decision to subgrant the RCs to the state’s seven public health districts allowed RCs to capitalize on existing public health district resources and adapt to community needs. However, this decentralized structure produced RCs that operated differently from one another and whose effectiveness was inconsistent. The same interviewee attributed the RCs’ varying success partly to the individual hired by each public health district as RC manager and partly to differences in the resources available, for example, in less-populated frontier areas.

“... what we didn’t want to do is micromanage them, but I do think that while we gave them a scope of work, we could have given them a little more detail, such as more guidance on the medical-health neighborhood. Some have taken off with it, and then others don’t”
—State official

RCs’ and clinics’ ability to address population health was hampered by delays in implementing a statewide data analytics system through the IHDE. RCs and clinics expected access to data through the IHDE that would allow them to identify and manage population health issues. These data were not available, however, because of the IHDE challenges described in **Section D.2.3**. A state official noted that RCs had access to some public health information (like immunizations) through the public health districts, but the limited information available did not fill the population health role envisioned for IHDE data.

Sustainability

Discussions of transition plans for RCs were under way; whether there would be an ongoing RC role after the end of the SIM Initiative was unclear and likely would differ by region. The staff who support the RCs were paid for by SIM funding that would not be available after the SIM Initiative ends. A state official deemed it unlikely that the full range of RC activities could be maintained. As part of sustainability planning, RCs were asked to identify which components of their responsibilities had value and to focus on a plan for maintaining those functions. Several interviewees saw a natural transition for RCs to a role in the Community Health Outcome Improvement Coalitions under the RCOs planned for Medicaid. However, Medicaid plans called for the RCOs to be rolled out initially in only two public health district regions, so they would not provide a bridge for all Idaho’s RCs.

D.3 Implications of Findings/Lessons Learned

The SIM Initiative achieved the following major milestones during the AR3 analysis period:

- Enrolled the third cohort of clinics, thus meeting the SIM Initiative goal of engaging 165 clinics in PCMH transformation.
- Attained national PCMH recognition for more than half of the clinics in the first two cohorts and qualification for enhanced Medicaid payments for almost two thirds.

- Created a peer mentorship program for clinics to sustain practice transformation after the SIM Initiative ends.
- Recognized 22 additional virtual PCMHs.
- Established 12 telehealth sites and initiated a Project ECHO model focusing on opioid addiction and treatment.
- Trained 23 community paramedics and 49 CHWs.
- Created bidirectional connections to the IHDE for 69 clinics.
- Continued development of new Medicaid VBP models.

Based on the SIM implementation experience in Idaho, several opportunities, remaining challenges, and lessons learned may be relevant for other states:

- Leveraging previous PCMH transformation initiatives and the relationships among a broad set of stakeholders established during those efforts made it possible for Idaho to meet its goals for provider recruitment and foster change within the state's delivery system, without legislative or regulatory mandates.
- Although engaging commercial payers was challenging, Medicaid was an effective partner in advancing health system transformation by incentivizing practice transformation that prepared practices to participate in other payers' VBP models.
- Maintaining broad stakeholder engagement, despite lack of alignment on payment models and quality measures, laid the foundation for longer-run agreements.
- Health IT and HIE are fundamental components of health system transformation, but connectivity, data quality, and analytics posed considerable challenges, and the time and resources required for these activities should not be underestimated. Opportunities for peer learning from other states that have encountered similar challenges, and TA available through the state's SIM participation, provided essential supports for advancing health IT and HIE development.
- Idaho found that, although rural providers could be engaged in practice transformation, rural practices were likely to need more intensive transformation support than practices in more urban settings with prior experience or additional resources available to them from hospital or health system affiliations. Idaho's experience also indicated there are additional barriers to implementing more advanced VBP models that involve risk-sharing in sparsely populated, rural areas.
- Provider shortages posed challenges for practice transformation, but payer reimbursement policies also impeded adoption of new types of care providers.
- Having the right leaders at the top levels of initiative governance and at partner organizations, and making changes in leadership when needed, were important for advancing the SIM Initiative's goals in Idaho.

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Appendix E: State Innovation Model in Model Test States: Iowa

Key Results from Iowa's State Innovation Model Initiative May 2017–March 2018

Strategies, progress, and accomplishments, May 2017–March 2018

- Several value-based purchasing contracts were established between Medicaid managed care organizations (MCOs) and accountable care organizations (ACOs).
- Progress was made toward sustainability by aligning with the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act of 2015 (MACRA) Quality Payment Program (QPP), building health information technology (health IT) infrastructure, and enhancing Statewide Alert Notification (SWAN) admission, discharge, and transfer (ADT) alerts.
- The launch of the Healthcare Innovation and Visioning Roundtable promoted collaboration and alignment on broad issues of health care transformation.
- Several Community and Clinical Care initiatives (C3s; formerly Community Care Coalitions) were focused on providing patient navigation for diabetic patients.

Stakeholder response to implemented strategies

- Medicaid managed care implementation is still perceived as a barrier to value-based purchasing progress.
- Mixed reactions to Medicaid value-based purchasing contracts were expressed by provider-affiliated stakeholders.
- Stakeholders approved Iowa's shift to focus on alignment with the MACRA.
- The Roundtable was viewed as a highly valuable tool to share perspectives and develop consensus.
- C3s experienced challenges shifting from a social determinants of health focus to a clinical focus.

Remaining challenges

- Changes in Iowa's administration contributed to delays and uncertainty about the SIM Initiative's future.
- Most managed care payments were still FFS with no link to quality.
- Value Index Score (VIS) data (i.e., encounter and claims data) were neither timely nor adequate for measuring quality.
- Medicaid providers were not yet broadly using the ADT alerts.

Sustainability after the SIM award

- Stakeholders expected value-based purchasing in Medicaid to continue.
- SIM leaders had confidence that the Roundtable would continue.
- Stakeholders were uncertain about the future of VIS investments.
- Stakeholders were doubtful that the C3s would be sustained.

Iowa's SIM Initiative began February 1, 2015. SIM Initiative leaders in the state intend to use the award to improve population health and access to affordable and accountable health care. To accomplish its goals, the state is focusing its SIM Initiative on aligning payers under value-based purchasing and equipping providers to focus on value-based outcomes and population health needs.¹

This updated overview of the Iowa SIM Initiative is based on analyses of data collected from site visits, stakeholder telephone interviews, state document reviews, and state program and evaluation calls between May 1, 2017, and March 31, 2018 (i.e., the Annual Report [AR]3 analysis period). Further details on the analytic approach are available in *Chapter 1*. Information on the number and types of stakeholders interviewed for the state is in *Table 1-1*. *Figure E-1* depicts the timeline of major Iowa SIM and SIM-related activities to date.

E.1 Key State Context and Progress Prior to May 2017

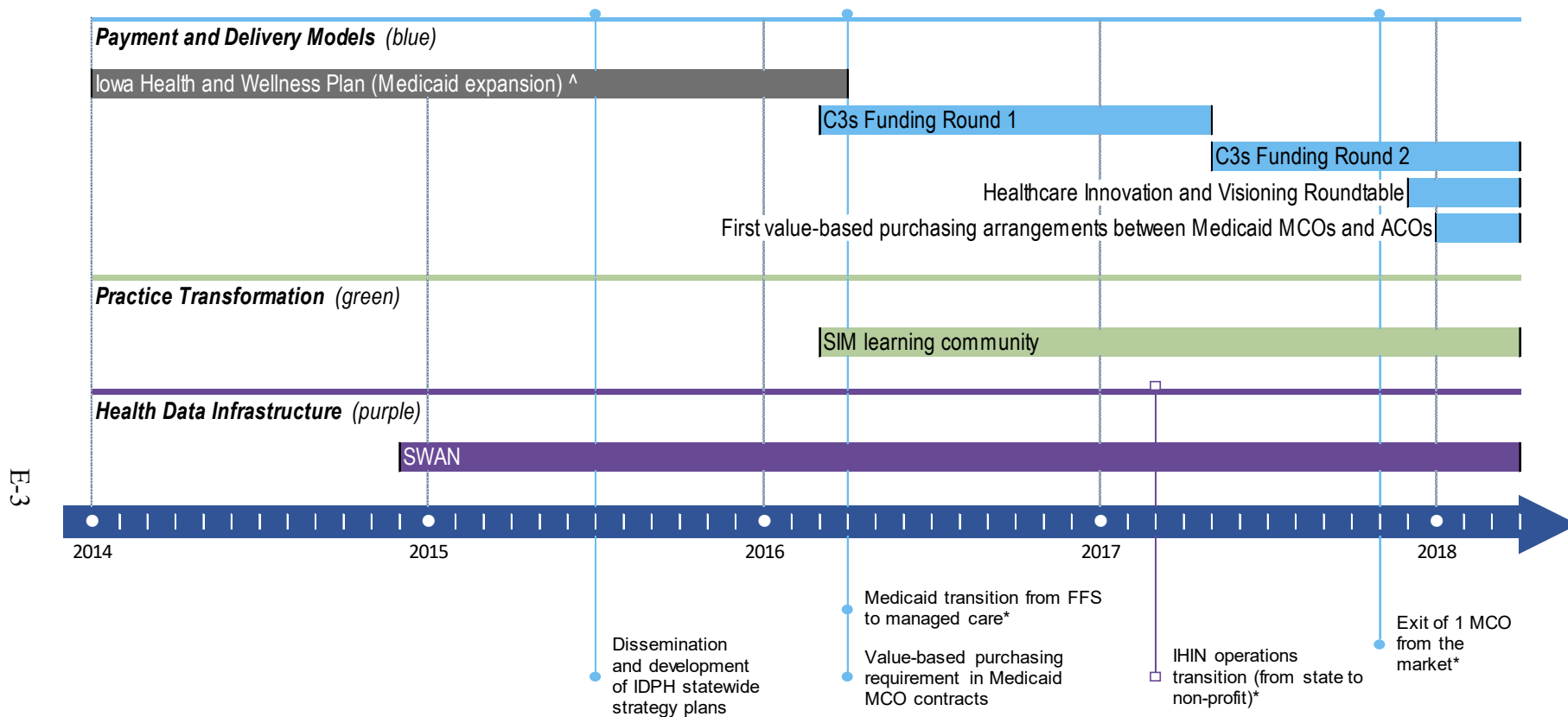
E.1.1 Pre-State Innovation Model health care in Iowa

Three unique features of the state impact Iowa's population health and health care environment: (1) its relatively small, largely nonmetropolitan population; (2) its highly concentrated health insurance market, with only a few key health care systems and payers; and (3) as a Medicaid expansion state, the recent expansion of the state's Medicaid program. Iowa's health care system has a history of productive collaborations and has engaged in several large, collaborative efforts to improve health and health care across payers, providers, and communities throughout the state.

Prior to the SIM award, Iowa had a predominantly FFS Medicaid program and a strong culture of successful ACOs that contracted with Medicare and Wellmark Blue Cross/Blue Shield, the dominant commercial insurer in the state. The state sought to use its SIM award to build on this healthcare delivery system foundation in designing a value-based purchasing program for Medicaid.

¹ Iowa Department of Human Services (DHS). (2018). *State Innovation Model (SIM)*. Retrieved April 25, 2018, from <https://dhs.iowa.gov/ime/about/initiatives/newSIMhome>

Figure E-1. Timeline of Iowa State Innovation Model and State Innovation Model-related activities



Note: The gray bar (with ^) denotes that the item is not a SIM activity or policy but is important for context.

Asterisks (*) denote that the items are not SIM policies but are important for context.

ACO = accountable care organization; C3 = Community and Clinical Care initiative (formerly Community Care Coalition); FFS = fee for service; IDPH = Iowa Department of Public Health; IHIN = Iowa Health Information Network; MCO = managed care organization; SIM = State Innovation Model; SWAN = Statewide Alert Notification.

E.1.2 State Innovation Model Initiative progress and changes prior to the Annual Report 3 analysis period

Iowa's primary goal for payment reform is to increase the prevalence of value-based contracts in the Medicaid program—seeking to have 50 percent of covered Medicaid lives under a value-based purchasing arrangement by the end of the SIM Initiative. The newly insured population under the Medicaid expansions was enrolled in ACOs via the Healthy Iowans program. Through the SIM Initiative, the state planned to eventually use an ACO model of care for the entire Medicaid population, with performance metric alignment across Medicaid, Wellmark, and Medicare ACO arrangements. The state chose to use Wellmark's VIS as the performance metric on which Medicaid value-based purchasing arrangements would be based to align with the state's largest commercial payer. However, this decision concerned some providers, who did not view the VIS as actionable for quality improvement or a good reflection of quality and also did not understand how the score was calculated. This SIM plan, which was designed in close collaboration with stakeholder groups, was widely seen in the state as the product of an inclusive and open process well tailored to Iowa's health care environment. The state's SIM investments in other supporting infrastructure focus on developing health IT systems and better integration of public health, medical care, behavioral health care, and long-term services and supports.

In early 2015, Iowa's Department of Health and Human Services announced that Medicaid would shift to a managed care system. The state's managed care strategy was intended to stem Medicaid's rising costs. Iowa's original SIM plan, which assumed a direct relationship between the state and providers, was reworked to reflect the change in Medicaid financing. Value-based purchasing would now be implemented through contracts between MCOs and providers. Managed care was implemented on an ambitious timeline: three new MCOs entered the state and began serving the vast majority of Medicaid beneficiaries (including the disabled and long-term services and supports populations) in April 2016.

During the AR2 analysis period, Iowa sought to align the project's value-based purchasing goals with those of Medicare, specifically the MACRA QPP. By the end of the AR2 analysis period (April 2017), Iowa had also begun shifting the state's population health activities toward clinical settings and away from community approaches.

The updates that follow discuss activities that took place during the AR3 analysis period (May 1, 2017–March 31, 2018).

E.2 Progress and Accomplishments from Iowa’s State Innovation Model Initiative, May 2017–March 2018

E.2.1 Delivery models and payment reforms

Key Results
<ul style="list-style-type: none"> • Successful implementation of multiple value-based purchasing contracts that began in early 2018. • The Healthcare Innovation and Visioning Roundtable was established by SIM Initiative leaders to build consensus among stakeholders on the future of health care transformation in Iowa. • Operational and administrative challenges related to Medicaid managed care implementation slowed value-based payment adoption, including the 2017 departure of one of the state’s three MCOs.

During the AR3 analysis period, Iowa made progress toward implementing value-based purchasing across health care payers, specifically in the state Medicaid program (*Table E-1*). Two Medicaid MCOs successfully negotiated state-approved value-based purchasing contracts with ACOs that began in early 2018. However, the third MCO had left the state in 2017, after a dispute over capitation rates, and operational and administrative challenges persisted in coordinating Medicaid managed care implementation and the SIM Initiative. Iowa also developed the Healthcare Innovation and Visioning Roundtable to build consensus among high-level stakeholders about the future of health care transformation in the state. Iowa SIM Initiative leaders and many stakeholders saw the Roundtable as a key component of the state’s strategy for stakeholder engagement and long-term sustainability.

Table E-1. Iowa’s progress on delivery system and payment reforms

Activity	Target population	Key activities	Progress between May 1, 2017, and March 31, 2018
Value-based purchasing	Iowa Medicaid beneficiaries	Promote value-based purchasing in Iowa Medicaid by expanding value-based contracting between MCOs and ACOs	<ul style="list-style-type: none"> • Iowa Medicaid Enterprise and the MCOs came to an agreement on a standardized template for value-based purchasing contracting with ACOs, including a framework for performance measurement. • Both MCOs still operating in 2018 negotiated multiple value-based purchasing contracts with ACOs and began implementing those contracts at the start of 2018.

ACO = accountable care organization; MCO = managed care organization.

Implementation of value-based purchasing in Medicaid

The two MCOs, both of which had a large national presence, that established value-based purchasing agreements with several different ACOs and provider systems at the start of 2018 used arrangements that varied in scope and sophistication depending on provider size and comfort with risk. The different agreements were similar, however, in that they tended to feature a shared savings component along with a per member per month (PMPM) payment or bonus for meeting a range of quality measure targets. For most providers, especially small ones, the MCOs used a standard contract template based on successful value-based purchasing programs they had already implemented in other states. For large providers with multiple value-based purchasing arrangements, the MCOs tailored contracts to allow physicians and managers to focus on core measures aligned across payers. Although the AR3 analysis period site visit took place too early to assess how providers were performing under these contracts, the MCOs generally felt that most providers would succeed under their value-based purchasing programs.

"[Our standard value-based purchasing program] is proven to effectuate results on the member level and cost level. It's easy to administer and frankly depending on the scenario it's easy [for providers] to earn. It's some very basic things they have to do to effectuate care. They've got to ask questions, engage the members and what happens based on our experience in other states is quality improves and cost goes down."

—MCO representative

Despite this optimism, stakeholders expressed concern that the rush to increase the share of beneficiaries covered under a standardized value-based purchasing arrangement to meet SIM goals had resulted in contracts that were less sophisticated than they could have been, given more time for careful consideration. One MCO representative explained, "You are not driving as much quality and improvement as you might if you had a considered process with a database, a better baseline year, a better idea of what the interest of the provider was instead of handing them something out of a box. Standardization at what cost is the issue."

Provider-affiliated stakeholders had mixed reactions to the newly implemented Medicaid value-based purchasing contracts. Some stakeholders were unaware that any value-based purchasing agreements between MCOs and ACOs were in place, and others were aware but had no direct involvement; some cited the lack of claims data from the MCOs as a reason they had not yet established value-based purchasing. Providers with contracts in place were cautiously optimistic, though some cited ongoing uncertainty around measurement standards for calculating baseline data and financial performance. Providers that had signed value-based purchasing arrangements also expressed frustration about the lack of a clear benchmark needed to qualify for shared savings, comparing the situation unfavorably to contracts they had in Medicare Advantage, which included clear targets. Some expressed concerns about the VIS and the ability to effectuate change using this tool. Providers did appreciate that contracts typically included a PMPM payment, which allowed them to fund the care management and coordination infrastructure necessary to meet performance goals (e.g., lower emergency room [ER]

readmissions), although provider stakeholders overall were skeptical they would reap financial benefit from shared savings arrangements. Some providers noted the MCOs' low capitation rates and their reported financial losses as indications that the health plans might not be able to provide "meaningful" shared savings incentives in value-based purchasing.

Many Medicaid providers in the focus groups said they had limited or no prior experience with value-based purchasing. Several mentioned scorecards and other types of performance reports providers had received as part of their ACO (most were affiliated with an ACO), and others said they had received bonuses for achieving targets for the metrics included in the reports. One provider said he did not know how to interpret the scorecard. Others expressed

"For instance, annual wellness visits were not at the top of the providers' mind [before it was a performance metric]. And so, we hired four nurses to do them and now...we've done a really good job of doing the visits for Medicare patients. Sometimes performance reports bring it to the forefront. If you don't know or think about it, you may not want to do it...it's just an improved awareness."

—Provider focus group participant

frustration over what they viewed as "one size fits all" rules for performance metrics (e.g., all patients under a certain age must have a screening) and the fact that their performance was measured on outcomes they sometimes felt powerless to influence—particularly when patients were noncompliant or when appointment times with patients were too short to provide health education and other resources providers knew were necessary to improve patient outcomes. A small number of focus group providers felt that performance metrics had served as motivation to focus more on prevention.

Value-based purchasing-related challenges

SIM stakeholders continued to perceive that Medicaid managed care implementation was a significant barrier to value-based purchasing progress. In focus groups, Medicaid beneficiaries shared their experiences with lengthy MCO prior authorization processes (typically for medications) and services not being covered, though some spoke positively about their experiences with MCO customer service departments. Medicaid providers included in focus groups echoed the beneficiaries' concerns, specifically related to prior authorization and step-therapy requirements for medications. In short, the work state officials and MCOs had to do to ensure basic managed care operations were up and running diverted attention away from efforts to transform care and promote payment reform.

"The magnitude of taking the entire state Medicaid population and putting them into managed care and dealing with provider and member problems took the focus away from what we were trying to accomplish and pushed back some of the VBP conversations. MCOs didn't want to talk about VBP [earlier in the SIM award period] because they were busy trying to figure out implementation."

—State official²

² Note that in this and other quotes from Iowa stakeholders, 'VBP' refers to 'value-based purchasing.'

Moving to managed care was highly controversial. Some providers saw managed care and the larger conversation around value-based purchasing and health care transformation in the state as one and the same. In contrast, other stakeholders continued to feel that the shift to Medicaid managed care had transformed the SIM Initiative from focusing on the needs of the state as a whole to focusing narrowly on Medicaid cost reduction; that is, the contentious nature of the managed care debate limited provider interest in engaging with the MCOs around value-based purchasing contracting. Yet other stakeholders reported a lack of communication from the DHS on how value-based purchasing would be implemented through the MCOs, as the state and payers focused on operations. Several stakeholders said the lack of trust around claims and payment posed a challenge to successful contract negotiations between the MCOs and ACOs. According to one ACO provider, “I would be hesitant to contract with one of the MCOs because they owe us so much money. I can’t really imagine bringing that to my CEO right now. Their heads might blow off.”³

Delayed claims data resulting from managed care implementation impeded efforts to enroll providers in value-based purchasing contracts. Stakeholders and state officials expressed frustration with the delay in obtaining reliable claims and encounter data from the MCOs; they viewed the delay as an inevitable side effect of the transition to managed care. In other words, until operational issues were resolved and claims paid accurately, providers would not have confidence in the underlying data needed to accurately attribute members, benchmark performance, and measure improvement in a value-based purchasing contract. One provider representative said, “We still haven’t seen claims data since April of 2016 onward. Nothing since the rollout of the MCOs. So, it’s extremely frustrating for us and would be hard for us to be able to enter into the VBP contracts when you don’t have the data to be able to verify.”

The departure of one MCO in late 2017 exacerbated concerns about the stability of the managed care program and negative perceptions of managed care in the state. The MCO departure required the DHS to transition 213,000 beneficiaries to another MCO; this change caused both a serious logistical challenge for the state and a major disruption for providers and patients. In focus groups, several Medicaid beneficiaries who had transitioned from one MCO to another expressed confusion about the forced change in their MCO, highlighting negative experiences obtaining their member card or prior authorization for prescription drugs from their new insurer.

Though less significant than managed care-related delays, Iowa experienced major changes in high-level health care leadership during the first half of 2017, which some stakeholders felt contributed to delays and uncertainty about the SIM Initiative’s future. These changes included a new Governor; the retirement of the long-serving DHS director, who

³ CEO = chief executive officer.

had played a major role in both managed care implementation and the SIM Initiative more generally; and the new DHS director’s background in child welfare rather than health care policy. In addition, the Medicaid director moved to become the Deputy Director of the DHS while the national search for her replacement was still ongoing. Furthermore, the inaugural meeting of the Healthcare Innovation and Visioning Roundtable was pushed back as new officials were brought up to speed on the SIM Initiative. All these factors combined to leave some stakeholders unsure about the new leadership’s priorities around the issues of managed care and value-based purchasing.

Despite these operational and administrative challenges, the state, MCOs, and provider systems were able to implement two value-based purchasing contracts that went into effect at the beginning of 2018.

Numerous in-person meetings between the DHS and MCOs during the previous year produced these agreements. The meetings focused on creating a value-based purchasing contract template that would be acceptable to all parties, with an emphasis on resolving issues of data and measurement (described further in *Section 2.3*). Although the discussions were reportedly tense at times, the parties generally agreed that the 6 months of work were valuable—not only for advancing value-based purchasing contracts but also for aligning the state and MCOs around a common vision for health care transformation.

“[The process of creating a value-based purchasing contract template with the state] required dealing with the essential of question of ‘Was it going to be the state’s program or was it going to be our program?’ The most important thing we resolved is that it going to be a combination of the two.”
—MCO representative

Efforts to align with Medicare and the Medicare Access and Children’s Health Insurance Program Reauthorization Act of 2015 provisions

Stakeholders saw the state’s shift to focus more on alignment with the MACRA as a valuable catalyst for provider interest in value-based purchasing and health care transformation. In the words of one state official, “It is getting the attention of the providers that fall under it to say [payment for] quality is really coming for us. It’s been helping us push the partnerships we need.” Generally, providers saw the MACRA as a major signal that value-based purchasing was inevitable and that providers would ultimately need to comply to preserve their practice. Some stakeholders wished the state had made the decision to align with the MACRA and Medicare earlier, particularly around measurement, rather than aligning with the commercial market through Wellmark’s VIS.

State officials continued to work with MCOs on alignment with the MACRA and pushed to include advanced alternative payment model (APM) principles during the contract negotiation process. One state official said Medicaid included roughly a dozen additional requirements in the MCO contracts for 2018 that began to “move the needle” toward MACRA requirements, such as a requirement that 50 percent of the MCO’s providers must use

certified health records. Still, state officials cautioned that significant work remained to be done to actually establish Other Payer Advanced APM criteria in Iowa, particularly as CMS rules clarified that only Medicaid payers would be eligible for Other Payer Advanced APM status in 2019, with private insurers such as Wellmark unable to qualify until 2022.

The Healthcare Innovation and Visioning Roundtable was established. To expedite alignment across payers and promote high-level stakeholder collaboration on broad issues of health care transformation, Iowa developed the Healthcare Innovation and Visioning Roundtable. Roundtable members include the leaders of large health systems, ACOs, Wellmark, the two Medicaid MCOs, and businesses around the state (including the Farm Bureau). The Roundtable’s inaugural meeting, which was delayed because of the health care leadership transitions described above, was held in December 2017, followed by a second meeting in February 2018. These initial two meetings focused on discussing broad trends in the delivery system and developing a mission statement for the Roundtable and a framework for health care innovation in Iowa. Given the level of engagement at the initial meetings, the full Roundtable and its work groups plan to continue meeting regularly in the future as Iowa continues to work on transforming its health care system.

State officials and stakeholders gave the Roundtable very positive feedback, viewing the Roundtable as a highly valuable tool to share perspectives and develop consensus on the most significant issues of health care delivery and financing. Stakeholders were anxious to reengage with the state after what they perceived as a lack of communication from DHS during the managed care transition. They particularly appreciated that new stakeholders such as business groups were included and that participants across the spectrum seemed committed to serious collaboration.

“It was interesting that everyone was very much on board [at the inaugural Roundtable meeting]. I think it helped that the Governor took a good leadership position on this and said it is a real priority.”

—Stakeholder

One stakeholder expressed concerns that the Roundtable would lead to a reimagining of SIM goals and further instability and uncertainty, but most appreciated the opportunity to work together on payment reform issues.

Sustainability

Stakeholders generally agreed that value-based purchasing in Medicaid would continue, especially as contracts become even more aligned with the MACRA QPP. SIM leaders were also confident that the Roundtable, which they considered a tool for long-term sustainable health care system change, would continue after the SIM award period. One state official explained how Roundtable members saw the entity as facilitating health care transformation but not necessarily the SIM Initiative itself, saying “[The members] don’t see an end date at all...the Governor was pretty clear when she came in saying ‘I don’t want this to be just another report. I want this to be transformative and a stepping stone to move us to

transformation.” To ensure the long-term success of value-based purchasing in Iowa and the broader SIM Initiative, the state hired Health Management Associates, the same group responsible for convening the Roundtable, to assist with sustainability planning for the final years of the project.

E.2.2 Progress toward a preponderance of care in value-based purchasing and alternative payment models

Key Results

- Given continued delays resulting from the implementation of Medicaid managed care, state SIM leadership reduced its goal for the percent of Iowa’s population in a value-based purchasing arrangement by the end of the SIM Initiative from 50 percent to 45 percent.
- Although the percent of Medicaid payments that are FFS with no link to quality increased in the data shown below, the data do not yet reflect 2018 value-based purchasing contracts with Medicaid.

Iowa does not expect to meet CMMI’s SIM goal of 80 percent of the total population in value-based purchasing arrangements by the end of the award period. During the AR3 analysis period, the state further adjusted their prior goal of 50 percent in value-based purchasing down to 45 percent (excluding Medicare) because of changes in both the commercial and Medicaid space.⁴ On the commercial side, an ACO contracted with Wellmark dropped out of a value-based purchasing arrangement to form its own health plan. On the Medicaid side, the departure of one of the three MCOs in the state, combined with delays in reaching an agreement between the state and the remaining two MCOs on their 2018 contracts, contributed to the downward adjustment.

Iowa Medicaid’s contracts with MCOs required that 40 percent of each health plan’s covered lives be in a state-approved value-based purchasing agreement. State officials were confident that both MCOs would be able to meet this requirement for 2018, noting that the MCOs already had other value-based purchasing contracts (though not necessarily state-approved ones). Stakeholders echoed the confidence that the 40 percent requirement would be achieved, though some described it as ambitious. One MCO compared the 40 percent goal to that of their national organization, noting that Iowa still includes a long-term goal of having 80 percent of the population in a value-based purchasing arrangement in the state’s vision for the post-SIM environment. In reflecting on the 80 percent goal, state officials noted that for providers to feel comfortable

“Our overall goal being in many markets for decades has been 30 percent spend in VBP. We’ve gotten our [Iowa Medicaid] membership up to 20 percent VBP in 60 days, honestly the level of participation we have gotten compared to other markets has been astounding.”

—MCO representative

⁴ These goals do not include the Medicare population because the state is unable to track value-based purchasing information for the Medicare program.

having such a large share of their business in risk-based arrangements, significant improvements would have to be made in data sharing, medical infrastructure, and the incorporation of the social determinants of health.

Table E-2 presents the extent to which Iowa’s population was participating in the SIM payment and health care delivery models as of the end of Award Year 2 (April 2017) and reported in the Award Year 3 Report 3 progress report to CMMI.

Table E-2. Populations reached by a value-based purchasing or alternative payment model in Iowa, latest reported figures as of Award Year 2 Annual Report

Payer type	SIM models		Landscape
	ACOs	SIM Initiative-wide	Any value-based purchasing or APMs
Medicaid	0 (0%)	0 (0%)	—
Statewide	—	—	686,865 (22.2%)

Source: Iowa SIM Quarterly Award Year 3, Report 3 Metric Template.

— = relevant data not provided in the data source; ACO = accountable care organization; APM = alternative payment model; SIM = State Innovation Model.

Note: The denominator was provided by the state and includes the total state population. Medicare is included in the denominator but not the numerator.

These figures, which reflect the data available to the evaluation team when this report was written, do not include the implementation of approved Medicaid value-based purchasing at the beginning of 2018. The state reported that 22 percent of Iowa’s non-Medicare population did participate in some type of value-based purchasing arrangement as of April 2017, but those arrangements were not approved by the state as being in alignment with SIM principles. This 22 percent figure as of April 2017 was a substantial drop from the 50.7 percent of the non-Medicare population that participated in a value-based purchasing model in the SIM baseline year (2015) under the original ACO-focused program. The value-based purchasing contracts in effect during the baseline year were cancelled when managed care was implemented.

As shown in *Table E-3*, at the end of Award Year 2, Medicaid and Wellmark had similar proportions of beneficiaries under a value-based purchasing arrangement. Roughly three-quarters of Medicaid and Wellmark payments were Category 1 FFS payments, with approximately one-quarter under value-based purchasing (Categories 2 through 4). Compared to data from Award Year 1 (baseline), both Medicaid and Wellmark had smaller percentages of payments in value-based purchasing as of Award Year 2 relative to Award Year 1. Medicaid’s proportion of beneficiaries in Categories 2 through 4 decreased by 8.58 percentage points over the same period, although Medicaid’s proportion of payments in Categories 3 and 4 increased (by 0.39 and 0.18 percentage points, respectively). Wellmark decreased the proportion of beneficiaries in Category 3 over the same period, with no beneficiaries in Category 4 at either timepoint.

Table E-3. Payers participating in a value-based purchasing or alternative payment model in Iowa, latest reported figures as of Award Year 2

Payer	Category 1 Payment: FFS with no link of payment to quality		Category 2 Payment: Payment linked to quality		Category 3 Payment: APMs		Category 4 Payment: Population-based payment	
	Number of beneficiaries	Percentage of payments	Number of beneficiaries	Percentage of Payments	Number of beneficiaries	Percentage of payments	Number of beneficiaries	Percentage of payments
Medicaid	563,608	79%	111,336	20.55%	24,832	0.39%	339	0.32%
Wellmark	1,429,629	72%	0	0%	384,135	28%	0	0%

Source: Iowa SIM Quarterly Award Year 3, Report 3 Metric Template.

APM = alternative payment model; FFS = fee for service; SIM = State Innovation Model.

As of Award Year 2, at least 19.6 percent of primary care providers (PCPs) in the state were participating in some type of value-based purchasing agreement, although no providers were participating in a state-approved value-based purchasing contract with a Medicaid MCO (*Table E-4*). This percentage is a significant reduction from the 45 percent of PCPs who participated in a value-based purchasing arrangement in Award Year 1 (baseline) and is attributable to the cancellation of value-based purchasing contracts with ACOs after Medicaid managed care was implemented. Both numbers may represent an underrepresentation as participation in Medicare value-based purchasing is not represented in the numerator, but Medicare providers were included in the denominator.

Table E-4. Providers participating in a value-based purchasing or alternative payment model in Iowa, latest reported figures as of Award Year 2 Annual Report

Provider type	SIM models		Landscape
	ACOs	SIM Initiative-wide	Any value-based purchasing or APMs
Providers	0 (0%)	0 (0%)	1,488 (19.6%)
Provider Organizations	0 (0%)	0 (0%)	—

Source: Iowa SIM Quarterly Award Year 3, Report 3 Metric Template.

— = relevant data not provided in the data source; ACO = accountable care organization; APM = alternative payment model; SIM = State Innovation Model.

Note: The denominator includes the total number of providers in the state. Medicare is included in the denominator but not the numerator.

E.2.3 Enabling strategies to support health care delivery transformation

Key Results
<ul style="list-style-type: none"> Challenges were encountered in getting MCOs and the state to agree on common performance metrics. The final agreement was characterized by both state officials and MCOs as a compromised balance between flexibility and standardization. Progress was made toward building the health IT infrastructure to collect and use clinical quality measures (CQMs) for value-based purchasing as required for alignment with the MACRA. Broader distribution of SWAN alerts and planning are needed to improve the usability of alerts.

The Iowa SIM Initiative continued to focus on two key strategies—quality measure alignment and health IT infrastructure development—to support the health care delivery transformation needed for providers to succeed under value-based purchasing (*Table E-5*). Both strategies largely remained in implementation/infrastructure building phases. Though challenges arose in getting the state and MCOs to agree to quality measures, they achieved a compromise in which the score comprised 20 percent VIS and 80 percent each MCO’s own measures.

Table E-5. Iowa’s progress on enabling strategies to support health care delivery transformation

Activity	Target population	Key activities	Progress between May 1, 2017, and March 31, 2018
Quality Measure Alignment	Medicaid beneficiaries	Standardization of value-based purchasing in Medicaid using a common quality tool (VIS) aligned with the largest commercial payer and incorporating CQMs for alignment with the MACRA	<ul style="list-style-type: none"> Compromise was reached between the state and MCOs on the share of the performance measurement attributed to the VIS. An environmental scan and provider readiness assessment were done to inform the development of health IT infrastructure to support the collection and use of CQMs in value-based purchasing.
Health IT	Medicaid providers	Development of a statewide ADT infrastructure to promote care coordination and reduce unnecessary ER use	<ul style="list-style-type: none"> Progress continued on connecting ACOs and hospitals to SWAN. As of March 2018, 54 of the state’s 118 hospitals and four of the five major Medicaid ACOs were receiving SWAN alerts. Funding was secured for the transition of SWAN to a new platform to improve alert usability.

ACO = accountable care organization; ADT = admission, discharge, and transfer; CQM = clinical quality measure; ER = emergency room; health IT = health information technology; MACRA = Medicare Access and CHIP Reauthorization Act of 2015; MCO = managed care organization; SWAN = Statewide Alert Notification; VIS = Value Index Score.

Quality measure alignment

Under the SIM Initiative, initial Medicaid contracts with MCOs required them to use the VIS, which is based on a total cost of care (TCC) methodology, as the primary source of value-based purchasing measurement. MCOs felt strongly that value-based purchasing arrangements should be based on a Medical Loss Ratio (MLR) methodology, which would line up with the method the state’s actuaries used to calculate the capitation rates MCOs were paid. In the words of one stakeholder, “If a capitated contract is based on an MLR but the total cost of care is measured differently for providers there is a lack of connectivity there.” MCOs pushed back on the VIS requirement because they were concerned about being held accountable on a cost measure that did not align with their payment structure.

Tension arose between the state’s desire to standardize value-based purchasing in Medicaid using a common quality tool and clear contracting guidelines and the MCOs’ preference to use their preexisting programs. All the MCOs, as subsidiaries of large national health plans with extensive experience in Medicaid managed care and value-based purchasing, already have established quality improvement and value-based purchasing contracting programs in many other states. Thus, they were reluctant to modify those programs to meet the demands of one Medicaid agency in a single health care market.

The state and MCOs ultimately reached a compromise. The VIS would represent 20 percent of the total quality score for any shared savings contract, and the MCOs would use their own measures (including MLR) for the remaining 80 percent. The state also committed to (1) separately track TCC for MCOs and analyze the data internally and (2) not release the TCC data to providers, to assuage MCOs’ fear that the data release would cause contractual issues if the two measures (TCC and MLR) diverged. Even so, the state hoped the two measures could be reconciled and a determination eventually made about which measure was the best to use in the future.

“To get a ship of our size to try and turn and pivot and change to fit a program the way one particular state wants to do it is a challenge. That very well had the potential to shift a lot of administrative burden to folks locally because we wouldn’t have been able to leverage the systems and processes that were in place across the organization.”
—MCO representative

State officials and MCOs both viewed this compromise as a workable arrangement that allowed for the right balance of flexibility and standardization. Discussions were aided by feedback the MCOs collected via negotiations with the ACOs—including provider reluctance to be assessed solely on the VIS, which is based on a proprietary formula they cannot calculate themselves.

The VIS is limited in that it is based on claims and encounter data, which are not ideal for measuring quality and are not available soon enough to inform clinical decision making for quality improvement. Clinical data collected through electronic health records

(EHRs) can provide better information for real-time decision making, quality improvement, and paying for quality. Collecting CQMs is also necessary for the Other Payer Advanced APM criteria Iowa is trying to achieve under the MACRA QPP. For these reasons, during the AR3 analysis period, the Iowa SIM Initiative focused largely on building capacity to collect CQMs, as described further in the next section.

Health information technology

The Iowa SIM Initiative has begun placing greater emphasis on building health IT capacity more broadly, particularly the capacity to collect and use CQMs. As part of this effort, the state conducted a statewide health IT environmental scan and provider readiness assessment to evaluate provider capabilities for reporting CQMs. The SIM team's ultimate vision is to support providers' decision making by building capacity to give providers access to real-time clinical data.

One capacity building step involved transitioning the administration of the Iowa Health Information Network (IHIN) from the IDPH to a nonprofit organization to facilitate CQM collection. As a state agency, IDPH was subject to legislative barriers that required a federated model for the IHIN, in which data stayed at its source rather than being combined at a centralized location. The primary focus of this type of model was on provider-to-provider health information sharing, and the model had limited capacity to support CQM collection, which requires aggregating information from multiple sources. Although this transition was not funded by the SIM Initiative, it will benefit SIM activities.

The state has been approved to receive Medicaid 90/10 matching funds to expand SWAN capabilities by building SWAN into the new IHIN platform. For example, the next iteration of SWAN will not only provide ADT alerts but also allow providers access to clinical information to inform their care decisions for patients being admitted, discharged, or transferred. The SWAN expansion will also include data analytics capabilities to enable population health management.

The current SWAN platform remains limited, but progress has been made in connecting more hospitals and delivery systems. In March 2018, 54 out of 118 hospitals in the state were submitting ADT information to the system. The state was also receiving eligibility files from both Medicaid MCOs and four of the five large Medicaid ACOs in the state. In addition, the SIM team expected to receive a Medicare eligibility file for Unity Point's Next Gen ACO population, which would expand SWAN alerts beyond Medicaid to Medicare.

While many SWAN alerts are being sent, state officials acknowledged the alerts were still not in the ideal format for incorporation into providers' work flows. Alerts are sent as a daily list of all patients from each ACO or MCO who had a hospital admission, discharge, or transfer. The Iowa SIM team described plans for a pilot in which selected organizations would send lists

of the high-risk patients for which they would like to receive alerts, thereby reducing the overall information flow while enabling more effective use of the SWAN alert system. The SIM team hopes this pilot will yield lessons that can be applied to SWAN users more broadly.


Stakeholders’ opinions on the usefulness of SWAN in its current form covered a wide range. Several stakeholders said they greatly appreciated the SWAN concept but did not know how best to take advantage of SWAN in practice. Others reported that the data were “messy” and lacked standardization, which made SWAN challenging to use. One ACO representative described the alerts as helpful for meeting transitions of care measures under their Medicaid value-based purchasing contract. However, another ACO said that using SWAN and the IHIN would be a step backwards from the capability the ACO already has with EPIC, the ACO’s EHR vendor.

Medicaid providers in the focus groups did not appear to be using the SWAN system. Some reported receiving ADT alerts through the EPIC system; others said they sometimes got routed notes that a patient had visited the ER and/or been admitted to the hospital. In the latter case, the notes were not consistent and occasionally outdated; that is, the provider first learned about a patient’s ER visit or hospital admission during a post-hospital office visit (i.e., before the provider had received any note). Most Medicaid beneficiaries in focus groups reported that their PCP did not receive an automatic notification when they visited the ER or were admitted to the hospital; usually, their PCP only knew about a hospital visit if the patient informed the provider him- or herself. A few said their MCO had followed up with them after an ER visit.

“[Providers] work those SWAN alert lists. Now if we don’t [meet targets for] three of those four measures [in our value-based purchasing contract] the ACO doesn’t get fed that month. Everyone has been real responsible. We missed a month of payments and that was a wakeup call. You have got to use it to do the hospital transition of care.”
—ACO representative

Sustainability

Stakeholders generally expected SWAN to be sustained in the future, though as a different tool with enhanced capacity because of the IHIN restructuring described earlier. Potential threats to sustainability that stakeholders mentioned included SWAN’s dependence on a robust IHIN platform (which is still being established) to support SWAN infrastructure. Despite general enthusiasm among stakeholders about the IHIN restructuring, past negative perceptions of the IHIN among providers, combined with competition from other health IT solutions such as PatientPing,⁵ could reduce the demand required to sustain SWAN after the SIM Initiative ends.

⁵ **PatientPing** is a national care coordination network that connects health care providers with real-time clinical event notifications whenever, and wherever, patients receive care: <https://www.patientping.com/> 

The future of VIS investments was unclear, including how the ongoing costs of VIS preparation would be covered after the SIM Initiative ends. One state official noted that the VIS was now a “solidly-established tool” in the state’s Medicaid program, making it difficult to imagine the VIS changing in the near term. At the same time, the Roundtable’s decisions will influence whether Medicaid continues to use the VIS, and feedback will be an important consideration once the MCOs and providers have more experience with using the VIS under the value-based purchasing agreements, which only started in early 2018. The emphasis on alignment with the MACRA through a move toward CQM use may also affect the status of the VIS in future value-based purchasing contracts.

E.2.4 Population health

Key Results
<ul style="list-style-type: none"> • Concerns exist regarding the state refocusing of activities from community to clinical settings in support of value-based purchasing. • New C3 contracts have decreased flexibility and more requirements (such as using the IHIN and SWAN). • Post-SIM sustainability is a potential future challenge.

The shift toward helping practices transition to value-based purchasing programs left some stakeholders feeling that the SIM Initiative’s emphasis had shifted from a community-based approach to addressing the social determinants of health toward emphasizing clinical settings. Although the intent was to facilitate further engagement of the health system in population health, realizing this intent remained challenging (*Table E-6*).

Community and Clinical Care initiatives

At the beginning of the AR3 analysis period, seven C3s were funded under the SIM Initiative: the six C3s established under the first round of C3 funding, and one new initiative that was formed and funded during the second round of funding. C3s have implemented many new activities under their revised scope of work for the second round of funding, and some C3s quoted their own initial data analyses as suggesting their initiatives had lowered readmission and ER visits in their communities.

Several C3s have focused on providing patient navigation for diabetic patients. One C3 reported it has improved diabetes measures for patients through home visits. Another C3 is coordinating existing diabetes navigation efforts in its community by providing a shared platform where organizations can track the patients they are working with and, thus, prevent duplication. Some C3s reported making progress in engaging their local health systems, particularly around the importance of social determinants of health in improving diabetes measures.

Table E-6. Iowa’s progress on population health

Activity	Target population	Key activities	Progress between May 1, 2017, and March 31, 2018
C3	Community in each C3 county	Establish locally based teams of health and social service stakeholders	<ul style="list-style-type: none"> Increased focus on working with the health system to improve clinical measures, particularly diabetes Shift away from building community capacity to address the social determinants of health
Statewide Strategy Plans	Statewide population	Develop plans that recommend evidenced-based approaches and clinical indicators for improving quality related to various health conditions and areas of care	<ul style="list-style-type: none"> Achieved further dissemination and use of the plans
Community-Based Performance Improvement Strategies	C3 staff	The Iowa Healthcare Collaborative and its subcontractors provided TA to C3s around community-based performance improvement, focused on diabetes.	<ul style="list-style-type: none"> Compiled a scorecard that was shared with each C3 community to inform their improvement efforts Organized site visits and learning communities to provide TA and promote best practices among C3s

C3 = Community and Clinical Care initiative (formerly Community Care Coalition); TA = technical assistance.

A few of the Medicaid beneficiaries in focus groups had experienced diabetes management programs (including through a public health department operating a C3), but they had mixed opinions of the programs’ effectiveness. One said of the home visiting program she was involved with, “They’re not, in my opinion, giving us information, they are looking for us to ask them. [The visiting nurse] comes out, asks you what your blood sugars have run, what’s your A1c, and that’s about all we seem to get.” Many of these Medicaid beneficiaries said their PCPs had referred them to a dietician for diabetes or weight management, and some mentioned enrolling in group diabetes education classes and receiving medical devices for diabetes management.

C3s reported challenges with the latest funding period’s shift in focus away from forming coalitions based on building capacity in the community to address social determinants of health and toward a more clinical focus. One C3 reported losing stakeholders when the new C3 funding request for proposal came out. Another reported narrowing the C3’s geographic reach given the new requirements they had to achieve—particularly having to better align its mission, work with other SIM components, and support the goals of value-based purchasing. Indeed, after this shift in focus, C3s had to promote the IHIN and SWAN and work with the local health system to improve clinical measures around diabetes. C3s were reportedly not yet using SWAN, but the SIM team hoped the aforementioned SWAN pilot, in which C3s would submit lists of high-risk patients for whom they want to receive ADT alerts, would make the system easier to use.

One strategy intended to help C3s engage local health systems was a new requirement to share 15 percent of C3 funding with a local health system, for example, to support part of a patient navigator’s time. One C3 succeeded in achieving the 15 percent share with a health system during the first program year, but others were unable to replicate this success. Representatives of some C3s reported that the health systems were not set up to accept or use money in this way and that the relatively small amount of funds did not justify the paperwork required to effectuate the transaction. In addition, some C3s felt the sharing requirement took money away from projects focused on social determinants of health that C3s themselves had been working on in their first program year.

In addition, although the health systems have reportedly been showing additional interest in the social determinants of health, that interest did not always open the door for further partnership. One C3 representative shared, “Our ACOs say we don’t need your help on this. We are doing fine and already meeting our measures.” Additional community organizations that have traditionally played a role in care coordination also expressed some frustration over the lack of willingness on the part of the health systems to partner.

“We even had a phone call [from a provider system wanting to build their own capacity to address social issues] interested in implementing a program, asking the C3 to provide TA. We said would you be willing to contract with us? We have been doing this since 2010 and have a lot of lessons learned. The answer is no. They want to hire their own staff.”

—C3 representative

Medicaid providers in the focus groups were generally unaware of the C3s in their counties, though a few shared positive experiences working with health coaches and social workers based on site at their ACO clinics. These providers said their health coaches, working in collaboration with PCPs, were responsible for discharge planning, follow-up after ER visits,

“If I have a newly diagnosed diabetic, I don’t have 45 minutes to sit and talk about how to change diet and check blood sugars and what A1c means and all this...It’s been really nice when the health coaches can step in.”

—Provider focus group participant

portions of the wellness exam, preventive care reminders, and helping patients prepare for their doctor’s appointments and manage their chronic conditions. Social workers helped arrange transportation and referred patients to housing assistance and food banks. Providers in the focus groups who did not work with health coaches or who had very limited access to social workers expressed

their desire for such resources, acknowledging how helpful they would be in improving their clinic’s health education efforts, ability to address the social determinants of health, patient compliance, and ultimately, health outcomes.

Statewide strategy plans

Most C3s felt the statewide strategy plans were useful because the plan development process involved working with stakeholders and identifying strategies for community-based health improvement. Several stakeholders found the statewide plans valuable, not only for the alignment of best practices across providers and other actors in the health system but also for the stakeholder engagement that occurred in the process of developing the plans. These stakeholders remained engaged in the SIM Initiative to update and disseminate the plans, and the statewide plan work groups reportedly stimulated new partnerships and activities. For example, one stakeholder reported that the Obesity Statewide Plan Work Group led to subsequent work by United Way around childhood obesity in Des Moines public schools. One stakeholder held the less-positive view that the plans were more “interest-driven than evidence-based.”

The statewide plan on diabetes was shared with non-C3 counties that mentioned diabetes in their Community Health Needs Assessment and Health Improvement Plans, as a prompt to begin considering the evidence-based strategies included in the statewide plan for their next update (updates happen every 5 years). An additional plan on the social determinants of health was also completed during this period and, like the rest of the statewide strategy plans, is meant to influence the activities of the C3s and the broader health care provider community.

Community-based performance improvement strategies

Through the TA the Iowa Healthcare Collaborative provided around community-based performance improvement, C3 communities have connected with the Collaborative’s subcontractors—such as the Iowa Pharmacy Association, Iowa Medical Society, and Iowa Primary Care Association—for information-sharing and assistance related to activities involving social determinants of health and referrals. C3s have additional data reporting requirements intended to help drive community-based performance improvement. These include a requirement to implement the AssessMyHealth HRA and build systems to collect data and track the patients they assist. Data from these sources feed into community scorecards the SIM team began producing and sharing with the C3s in their second program year. The C3s generally did not find their first scorecard to be usable or actionable, at least in part because it contained incomplete data. More generally, the scorecards were reported to remain in early stages of development. Additionally, Iowa Healthcare Collaborative held three SIM learning communities during the AR3 analysis period. Iowa SIM staff, Iowa Healthcare Collaborative staff, and representatives from C3s and large provider systems presented on topics such as care coordination, ACOs, and social determinants of health.

Various stakeholders reported difficulty implementing AssessMyHealth, which is required for C3s and encouraged for Medicaid providers. Some ACOs were not interested in implementing a new assessment because they have their own HRA connected with an EHR, which makes the information much more usable. An ACO without its own HRA expressed a

desire to have a form that was connected to other electronic records, noting that AssessMyHealth is in a Portable Document Format (PDF) file and not usable to inform patient care.

Stakeholders were more positive about the case management system they were required to implement to track patients receiving navigation services. C3s generally found the systems useful, although some had to contribute additional funding to comply with the tracking requirement because SIM funds were not enough to cover the software. One C3 suggested that it would have been more efficient for C3s to pool together and purchase one case management system, rather than each having to build or buy a separate system. Another C3 valued its system’s ability to screen patients for social needs and track successful connections to community resources, adding that eventually, data from the system should help C3s determine the case management system’s return on investment (ROI).

“For us [administering the HRA] is collecting data for the sake of collecting data rather than doing something that we can act upon. ...They told us the assessment takes 10 minutes to complete. We took it to a patient’s home so they could have a copy and it took an hour.”

—C3 representative

Sustainability

Stakeholders were doubtful that the C3s would be sustained after the SIM Initiative ended. Some stakeholders’ views were based on perceptions that the C3s were not very effective. Other stakeholders could not envision a sustainable funding source for the C3s. As noted above, health systems (one potential funder for the C3s) often wanted to build and use their own capacity to coordinate care and address social determinants of health. Medicaid MCOs (another potential funder) also had their own programs and strategies they could adapt from other markets. State officials acknowledged the challenge of C3 funding after the SIM Initiative, one saying, “What might be sustained from C3 work is a change in culture so that health systems do business better, serve people differently, look at the whole person.... SIM taught health systems and public health to work together and there’s value in that.”

E.3 Implications of Findings/Lessons Learned

The SIM Initiative achieved seven major milestones during the AR3 analysis period:

1. Establishment of several value-based purchasing contracts with Medicaid MCOs and ACOs and provider systems
2. Agreement on common performance measures that balanced alignment with SIM goals and flexibility for each MCO
3. Progress toward building capacity to collect and use CQMs for value-based purchasing for alignment with the MACRA
4. Broader dissemination of SWAN alerts

5. Sustainability vendor hired to start the process of sustaining progress after the SIM Initiative ends
6. Refocus of population health activities on clinical settings and supporting value-based purchasing
7. Establishment of the Healthcare Innovation and Visioning Roundtable to promote high level stakeholder engagement in the future of payment reform and sustainable health care transformation in Iowa.

Based on the SIM implementation experience, stakeholders offered several opportunities, remaining challenges, and lessons learned for other states:

- Despite progress on implementing value-based purchasing arrangements in Medicaid, such arrangements were not yet common or advanced enough to drive widespread changes in the delivery system.
- Tension between the desire for standardization and the benefits of providing MCOs with flexibility is an ongoing challenge that states pursuing similar initiatives in a managed Medicaid environment should consider carefully.
- Iowa benefited from a generally collaborative environment and a limited number of major stakeholders, including one dominant commercial insurer and a handful of large health care provider systems and ACOs.
- Ongoing sustained discussions between the state and MCOs helped overcome substantial challenges around value-based purchasing and quality measurement that stemmed from the transition to a managed care system.
- Efforts to align value-based purchasing initiatives in the state with the MACRA and Medicare helped drive provider engagement and interest in SIM activities.
- The decision to model the state's common quality tool for Medicaid on a proprietary product developed for the commercial market was a barrier to achieving agreement on a value-based purchasing template among payers, providers, and the state.
- Efforts to facilitate and sustain community-based population health initiatives such as C3s will likely require greater financial integration between public health and provider systems than has yet been achieved in Iowa. The state's efforts to foster such integration by mandating that C3s set aside a portion of their grant money for local hospitals faced several barriers.
- Collaboration among MCOs, C3s, and providers is crucial to successfully implement a care coordination strategy that is not duplicative and maximizes each entity's skills and resources.
- Developing ADT infrastructure is not enough to ensure SWAN's success; sustained TA and engagement by SWAN administrators are needed to enable providers to use the data effectively in delivering patient care.

- A common HRA tool (e.g., Iowa's AssessMyHealth) has the advantage of uniform data collection across payers and providers. However, some Iowa stakeholders were frustrated that the HRA adopted by the state's SIM Initiative (1) took a long time to administer and (2) was not integrated with EHRs and, thus, did not provide actionable information.

Appendix F: State Innovation Model in Model Test States: Michigan

Key Results from Michigan's State Innovation Model Initiative May 2017–March 2018

Strategies, progress, and accomplishments, May 2017–March 2018

- A standardized social determinants of health (SDoH) screening tool was developed and rolled out for use by CHIRs, patient-centered medical homes (PCMHs), social service agencies, and other community organizations.
- All 11 Medicaid health plans collected and submitted their baseline alternative payment model (APM) data.
- Hubs and referral tracking systems were developed for all five Community Health Innovation Regions (CHIRs).
- Practices were on-boarded to the state's health information exchange, enabling practices to receive admission, discharge, and transfer (ADT) alerts and learn how to best utilize the data.
- The Michigan Department of Health and Human Services (MDHHS) implemented a variety of technical assistance (TA) strategies to support PCMHs and CHIRs.

Stakeholder response to implemented strategies

- Stakeholders perceived the PCMH Initiative to be running smoothly and beginning to achieve improvements in care management and care coordination.
- Stakeholders reported that PCMH per member per month (PMPM) payments worked smoothly.

Remaining challenges

- Unrestriction requests for certain CHIR activities were delayed.
- Tension was apparent between certain provider groups and Medicaid health plans on which was better positioned to provide care management and coordination services.

Sustainability after the SIM award

- Health plans reported their perceptions that value-based payment (VBP) would continue and grow.
- PCMHs were concerned about funding mechanisms for care coordination and care management.
- Uncertainty about the sustainability of CHIR hubs and governance structures prevailed.

Michigan's SIM Initiative was awarded to the MDHHS and began on February 1, 2015. SIM Initiative leaders in the state intended to use the award to build a health care system that provided better quality and patient experience at a lower cost than the existing system. The state aimed to operationalize these goals through three strategies related to (1) population health, (2) care delivery, and (3) technology.

This updated overview of the Michigan SIM Initiative is based on analysis of data collected from site visits, stakeholder telephone interviews, state document reviews, and state program and evaluation calls between May 1, 2017, and March 31, 2018, the Annual Report

(AR)3 analysis period. Further details on the analytic approach are available in *Chapter 1*. Information on number and types of stakeholders interviewed is in *Table 1-1*. *Figure F-1* depicts the timeline of major Michigan SIM Initiative, and SIM-related, activities to date.

F.1 Key State Context and Progress Prior to May 2017

F.1.1 Pre-State Innovation Model health care in Michigan

Michigan is a large state with several large urban centers and major rural populations. The state's health care environment is characterized by large integrated health systems and state Provider Organizations. The Medicaid managed care market is reasonably competitive. Eleven Medicaid health plans operate throughout the state, and none has a majority market share. The MDHHS has an ongoing history of participating in many federal health care demonstrations—including Health Care Innovation Awards, the Multi-Payer Advanced Primary Care Practice Demonstration, Comprehensive Primary Care Plus (CPC+), and the Pioneer Accountable Care Organization Model. Stakeholders described the state as innovative in the field of health care delivery and VBP mechanisms and pointed to demonstrations that predated the SIM Initiative in the state and set a foundation for the SIM work.

The Michigan Primary Care Transformation (MiPCT) project was particularly critical in laying the groundwork for the SIM Initiative. The MiPCT was part of the Multi-Payer Advanced Primary Care Practice Demonstration that began in 2012 in an effort to increase medical home adoption throughout the state. The MiPCT included Medicare, Medicaid health plans, and three managed care organizations—Blue Cross Blue Shield (BCBS) of Michigan, Blue Care Network, and Priority Health. Other programs that helped build the SIM foundation in Michigan included (1) the Michigan Children's Health Access Program,¹ a community-based pediatric medical home model launched in 2008 and implemented in nine counties, several of which overlap with counties where initial SIM implementation got under way; (2) the Physician Group Incentive Program,² a medical home practice transformation program BCBS of Michigan supported; and (3) the MiHIN, the state's Health Information Exchange, established in 2010.

¹ Michigan Association of United Ways. (2016). *Michigan Children's Health Access Program*. Retrieved July 25, 2016, from <https://www.uwmich.org/michap/> 


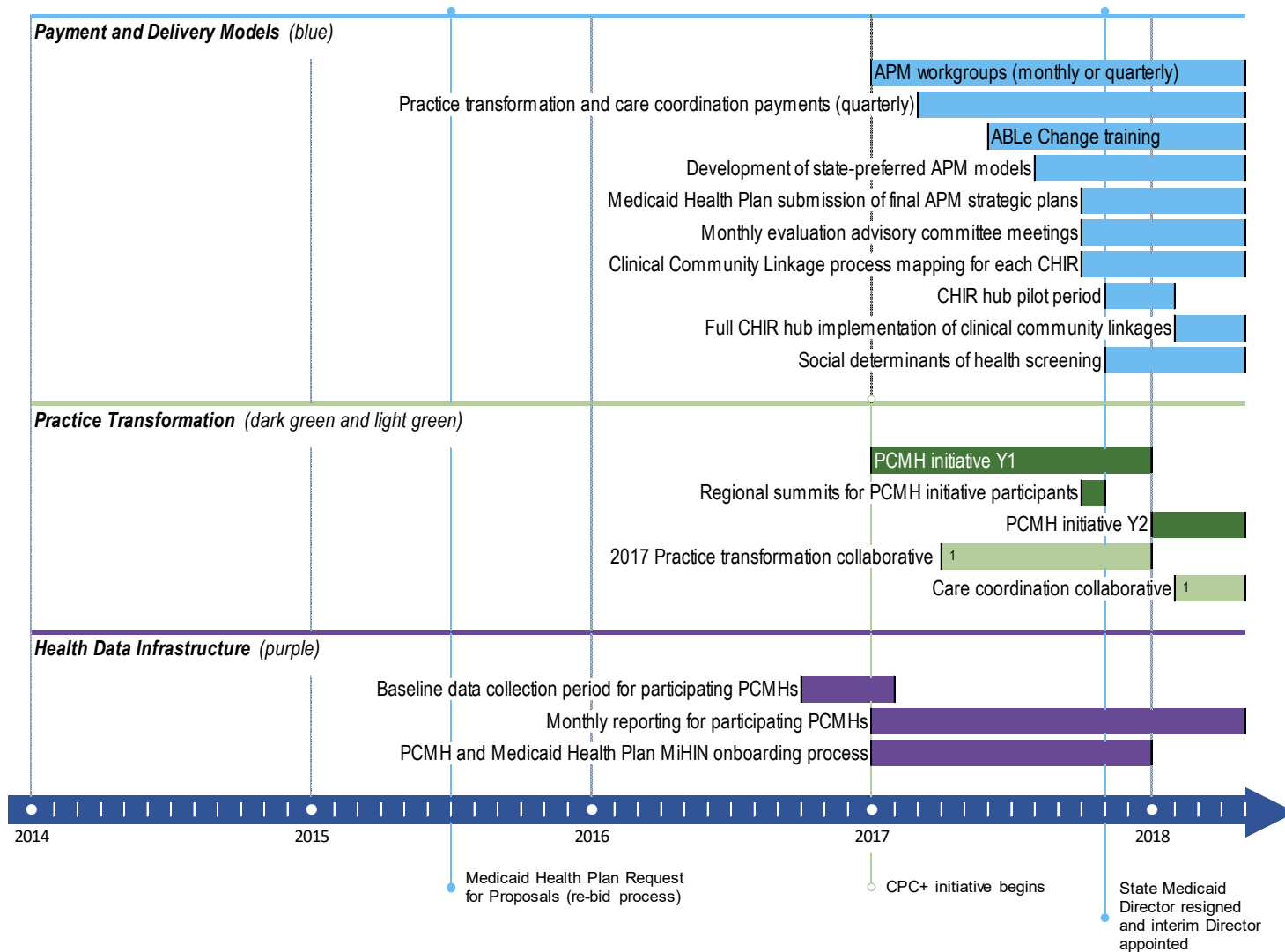
² BCBS. (2016). *About the Physician Group Incentive Program*. Retrieved April 20, 2016, from <https://www.bcbsm.com/providers/value-partnerships/physician-group-incentive-prog.html> 

Figure F-1. Timeline of Michigan State Innovation Model and State Innovation Model-related activities



F-3

Note: Lighter shades (with ¹) of the same color bars denote similar activities or models.

APM = alternative payment model; CHIR = Community Health Innovative Region; CPC+ = Comprehensive Primary Care Plus; MiHIN = Michigan Health Information Network; PCMH = patient-centered medical home; Y = year.

F.1.2 State Innovation Model Initiative progress and changes prior to the Annual Report 3 analysis period

Michigan’s SIM Initiative, housed within the MDHHS, is broadly organized into three categories: population health, care delivery, and technology. Through the SIM test period, the state aims to make improvements in care delivery and population health and support APM adoption.

In 2015, Michigan released a Request for Proposals for Medicaid health plan contracts, which included several provisions within the requirement that such health plans participate in the SIM Initiative. For example, Medicaid health plans were required to (1) distribute PMPM payments to participating PCMHs via the state’s Medicaid program and (2) collaborate with PCMHs on delivery reform and with CHIRs on population health strategies.

Originally, Michigan had also proposed creation of Accountable Systems of Care (ASCs) to facilitate quality improvements and reductions in expenditures through payment incentive alignment and improved care coordination. However, by April 2017, the state had moved away from the ASC concept, primarily in response to feedback from Medicaid Health Plans that argued that risk-bearing ASCs would duplicate the existing risk-bearing role of health plans. At that time, the PCMH Initiative was progressing according to plan, although some components of the CHIRs and health information technology were progressing slower than planned. Interviewees shared different reasons for this, including turnover at the state level and an overly optimistic timeline.

F.2 Progress and Accomplishments from Michigan’s State Innovation Model Initiative, May 2017–March 2018

F.2.1 Delivery models and payment reforms

Key Results
<ul style="list-style-type: none">• Practices participating in the PCMH Initiative began to roll out the SDoH screening tool to all patients.• The focus on reducing unnecessary emergency room (ER) use among patients in PCMH practices continued.• All 11 Medicaid health plans collected and submitted their baseline APM data.

Michigan aimed to support PCMHs participating in the PCMH Initiative—as they tested service delivery models to achieve better care coordination, lower costs, and improved quality of care and health outcomes for Michiganders—with PMPM payments (*Table F-1*). As of March 2018, some 328 PCMHs representing 2,163 attributed beneficiaries participated in the SIM Initiative. About half of the PCMHs, and more than half of the attributed beneficiaries, were located in one of five SIM regions—three single-county regions (Genesee, Jackson, and Muskegon), one 2-county region (Livingston-Washtenaw), and a 10-county region in Northern Michigan.^{3,4}

Table F-1. Michigan’s progress on delivery system and payment reforms

Activity	Target population	Key activities	Progress between May 1, 2017, and March 31, 2018
PCMH Initiative	All Michigan residents, with a focus on Medicaid beneficiaries	Implementation of the SDoH screening tool	<ul style="list-style-type: none"> PCMHs throughout the state began implementing the SDoH screening tool in late 2017 and early 2018. Each CHIR developed a different process for handling referrals.
Medicaid health plan APMs	Medicaid health plan enrollees	Collecting baseline data about APM activities, progressively adopting more advanced APMs	<ul style="list-style-type: none"> All 11 Medicaid health plans completed and submitted baseline APM data collection.

APM = alternative payment model; CHIR = Community Health Innovation Region; PCMH = patient-centered medical home; SDoH = social determinants of health.

Michigan also continued to leverage the SIM Initiative as an opportunity to increase adoption of VBPs across the state’s 11 Medicaid health plans. These plans were contractually obligated to collect and report baseline data on (1) the percentage of payments with an APM component, and (2) the share of spending through APM arrangements. In late 2017 and into early 2018, the state worked closely with the Medicaid health plans to collect the necessary baseline data on APMs.

³ The 10 counties included in the Northern CHIR region are Antrim, Benzie, Charlevoix, Emmet, Grand Traverse, Kalkaska, Leelanau, Manistee, Missaukee, and Wexford.

⁴ MDHHS. (2018, March). *SIM Initiative Newsletter*. Retrieved from https://www.michigan.gov/documents/mdhhs/SIM_Newsletter_March_2018_618857_7.pdf

Implementation of delivery system reforms

Beginning in late 2017, practices participating in the PCMH Initiative were required to implement the SDoH screening tool for all patients in their practice as part of their practice transformation requirements.

Practices within CHIRs were able to meet these requirements by referring patients to their CHIR hubs, either directly or through a Provider

Organization. The MDHHS developed the SDoH screening tool to help practices identify barriers that might impact a patient’s ability to achieve optimal health and wellness. The screening tool included questions on health care, food, employment and income, housing and shelter, utilities, family care, education, transportation, and personal and environmental safety. By March 2018, practices were still in the process of rolling out the screening tool, which some practice-level interviewees had not yet heard about. Other practice staff reported that they were already collecting some social determinants of health data but that the SIM Initiative’s SDoH screening tool presented an opportunity to collect the information in a more systematic way.

“We’ve been assessing [for social need] already, but not really in a systematic way. We’re waiting for the community linkages to finalize the [SDoH screening] tool and then we’ll start using it with all our patients at their first visit and then annually after.”

—PCMH staff

The MDHHS allowed CHIRs, the state’s Provider Organizations, and PCMHs to alter the screening tool, as long as they maintained the major domains of the original (e.g., transportation, housing); most implemented the screening tool unchanged. Practices also worked with their CHIRs or Provider Organizations to develop protocols for what steps to take after a need is identified on a version of the SDoH screening tool. These protocols varied by practice and by region, and many practices were still developing their plans in March 2018.

Transportation, housing, and food insecurity emerged as needs across regions. CHIR and PCMH staff reported that the SDoH screening tool was highlighting what they already knew about their communities—significant needs across all domains but especially in transportation, food, and housing. Interviewees were looking forward to having region-wide data to illustrate these needs and commented that the SIM Initiative presented an opportunity for health care and social service providers to connect.

“There’s a form you fill out...it asks if you are suicidal, do you eat, do you sleep...so I guess if you’re suicidal, depressed, or some of these kinds of things, it would give them some indication to ask you [when you see the provider].”

—Medicaid beneficiary focus group participant

Few Medicaid beneficiaries in focus groups recalled having received a screening tool asking about nonhealth needs. Of the 18 Medicaid beneficiaries who participated in focus groups, only 3 described recent visits to their primary care provider in which they were asked to fill out a questionnaire related to social determinants of health—the first time they had been asked to do so. These patients noted that it contained questions about whether they had experienced depression and whether they had any trouble getting transportation to doctor’s appointments or to work. One focus group participant appreciated that her provider was showing interest in her mental health. Another expressed the contrary view that the questions were too personal and not relevant to her health. The third participant recalled learning about a free transportation resource available to her through her Medicaid health plan after she had identified a transportation need on the questionnaire.

“I’m not even sure I want my medical doctor to know I might have some financial issues and that I need [other services]. I’m not sure I’d want to discuss that, to be honest with you.”
—Medicaid beneficiary focus group participant

Care coordinators and care managers worked to help practices reduce unnecessary ER use. One practice described a new data report it began receiving in January 2018 from the local health network that showed patients with recent ER utilization. Care coordinators and care managers at that practice used the list to systematically contact patients to check in after an ER visit and to provide education about appropriate ER use whenever possible. Focus group providers echoed the same strategy when they reported that care managers and care coordinators at their practices were focused on reducing unnecessary ER use. From the perspective of many providers who participated in interviews or focus groups, the SIM Initiative was primarily aimed at reducing ER use. Several focus group providers reported that they had used care coordinators and care managers previously but that those roles had changed somewhat under the SIM Initiative to encompass more follow-up with patients after a hospitalization.

“[Before SIM], we had [care coordinators and care managers], but they functioned in a very different role than they do now. They are much more doing case management and care management for our patients. Following up more on the discharge from the hospital.”
—PCMH provider focus group participant

Most interviewees thought the PMPM payments for care coordination and practice transformation (ranging from \$3.00 to \$7.00) were helpful to practices but not sufficient to cover the amount of effort associated with these tasks. The PMPM payments were described as having been effective in helping practices embrace the concept of care management. Some practices were also participating in CPC+, which allowed them to receive payment for care coordination of Medicare enrollees. Taking CPC+, the SIM Initiative, and some private payers’ care coordination payment arrangements together, many practices were able to access reimbursement for providing care coordination services regardless of payer type. Looking forward, state staff hoped the Medicaid pass-through payment structure implemented under the

SIM Initiative would lay the groundwork for sustainability because Medicaid health plans were getting accustomed to making payments to practices for care coordination and care management. The SIM payment process is different from the previous MiPCT initiative, however, under which the state paid practices directly (without involving the health plans). It is important to note that these payments to practices are not from each Medicaid health plan’s contractually agreed-upon capitated payment but from the State’s Medicaid agency.

Implementation of alternative payment models in Medicaid

In late 2017 and early 2018, the 11 Medicaid health plans worked with the MDHHS to collect and report data on the percentage of payments they were making in each of four Health Care Payment-Learning and Action Network (HCP-LAN) framework categories (1 = fee-for-service (FFS) with no link to quality, 2 = payment linked to quality, 3 = APM payment, and 4 = population-based payment). Given this baseline data collection, each of the Medicaid

“[The MDHHS] is actively building quality strategies into Medicaid contracts and in their performance incentive pools to move to more Category 3 and Category 4 type payments. It’s still early but I think it’s working well so far. The plans are engaged in the conversation, and they’re working with their contracted providers to find ways to move the mark.”

—Health plan representative

health plans was required to develop a strategic plan related to APM adoption. The MDHHS was also in the process of developing performance incentive pools to encourage plans to move into progressively more advanced HCP-LAN framework categories (i.e., from Categories 1 and 2 to Categories 3 and 4). At the same time, the Medicaid health plans worked with the state to develop data collection tools to facilitate measurement under the SIM Initiative. Interviewees from the Medicaid health plans reported that they were pleased with their level of communication with the state about APM development and were optimistic that they would continue to move up the HCP-LAN framework over the next few years. However, one health plan representative reported that certain providers “just aren’t interested in taking on risk, and are looking for fee-for-service or capitated payments.”

Medicaid health plans conducted quality reporting activities as part of the SIM Initiative, placing at least some of their payments in HCP-LAN Category 2. Interviews with health plan representatives confirmed that all Medicaid health plans were conducting SIM-required quality reporting activities. This meant that, by definition, all Medicaid health plans in Michigan were conducting some level of payment activity in Category 2 (*Section F.2.2* discusses the results of Michigan’s baseline APM measurement in detail).

Overall, interviewees found the state proactive in soliciting feedback from the Medicaid health plans on the topic of APMs, but participating practices and the state’s Provider Organizations seemed unaware of state efforts to support VBP. From the beginning of the SIM Initiative, the state conducted regular workgroup meetings to engage the

Medicaid health plans on APM issues. In summer 2017, the state also conducted a survey to collect provider feedback on APMs. State and health plan representatives were optimistic that this level of collaboration would help encourage APM consistency across plans. To further encourage consistency, by the end of the AR3 analysis period, the state was in the process of developing several APM models based on the feedback.

Several Medicaid health plan interviewees expressed the need for a value proposition that would persuade the health plans to fund care coordination in the long term out of their capitated payment. In some CHIRs, the state’s Provider Organizations were beginning to have conversations with health plans about where care coordination functions should be centralized (i.e., at the Provider Organization or Medicaid health plan level) and how the two types of entities can work together to achieve cost savings while supporting care coordination. Although most provider and Provider Organization staff had not heard of state efforts to encourage APMs, several interviewees mentioned that the state was working to develop an FFS code to reimburse community health worker (CHW) time.

“My understanding is that the state isn’t doing anything [related to APMs]. If SIM ended tomorrow, the health plans would be deciding independently whether they’d continue paying for embedded care management.”
—Medicaid health plan representative

Sustainability

Stakeholders emphasized the need to create a value proposition for care coordinators and care managers but were unsure how effective SIM activities would be at creating sustainable VBP arrangements. PCMH staff universally praised the concept of care coordination and were eager to find funding mechanisms to support it in the long term. Some Provider Organizations had already begun negotiating with health plans, including commercial health plans, to develop sustainable payment mechanisms to support care coordination.

None of the PCMH staff interviewed was familiar with state efforts to support APMs so could not comment on the potential sustainability of that component of the SIM Initiative. Tension also existed between health plans, Provider Organizations, and PCMHs about who should employ care coordinators. In some regions, care coordinators were employed both through Provider Organizations (and less commonly directly by a practice) and by Medicaid health plans. Stakeholders of all types commented on the potential for duplication of effort, but some disagreement emerged about which care coordinator should manage a given patient.

F.2.2 Progress toward a preponderance of care in value-based payment and alternative payment models

Key Results
<ul style="list-style-type: none"> Michigan is unlikely to reach the 80 percent preponderance of care goal before the end of the SIM Initiative.

Stakeholders did not expect Michigan to meet CMMI’s SIM goal of 80 percent of the total population in VBP arrangements by the end of the award period. By the end of the AR3 analysis period, only Medicaid health plans were participating in the SIM Initiative. State officials reported that the state did not have the leverage to require commercial payers to participate in the SIM Initiative or in VBP. Even among the Medicaid health plans, interviewees expressed doubt that the state would meet the 80 percent goal during the SIM Initiative. One health plan representative cited provider pushback as a factor detracting from the state’s ability to reach the goal. Another health plan representative was not familiar with the 80 percent figure but commented that it was “very high.” One provider suggested that it would be difficult to reach the 80 percent goal because an FFS mindset is still so entrenched for many providers.

Table F-2 presents the extent to which Michigan’s population is participating in the SIM payment and health care delivery models. The state provided these values in its Award Year 2, Report 5 progress report to CMMI.⁵ This table includes data from the most recent quarterly report ending January 2018.

Table F-2. Populations reached by a value-based payment or alternative payment model in Michigan, latest reported figures as of Award Year 2, Report 6

Payer type	SIM models		Landscape
	PCMHs	SIM Initiative-wide	Any VBP or APMs
Medicaid	333,501 (16.3%)	333,501 (16.3%)	—
Statewide	—	—	—

Source: Michigan SIM Quarterly Progress Report for Award Year 2, Report 6.

— = relevant data not provided in the data source; APM = alternative payment model; PCMH = patient-centered medical home; SIM = State Innovation Model; VBP = value-based payment.

Note: The denominator (Medicaid population totaling 2,044,959) was provided by the United States Census Bureau American Community Survey 5-Year Estimate 2012-2016

(<https://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml>; accessed May 31, 2018).

⁵ Michigan had six “quarters” in 2017 because of a no-cost extension that added two “quarters” (or reporting periods) to 2017.

As shown in **Table F-2**, Medicaid beneficiaries received care through a SIM PCMH in the most recent reporting period. This figure includes beneficiaries attributed to SIM PCMHs both within and outside CHIRs. The number of beneficiaries attributed to a SIM PCMH has remained relatively stable over the course of the SIM Initiative but was at its lowest reported value in the most recent reporting period (the highest was 353,825 in Award Year 2, Report 3).

Table F-3 presents the number of Michigan’s providers participating in the SIM payment and health care delivery models. A total of 2,163 providers worked in 328 PCMHs participating in the SIM Initiative, as of the most recent reporting period.

Table F-3. Providers participating in a value-based payment or alternative payment model in Michigan, latest reported figures as of Award Year 2, Report 6

Provider type	SIM models		Landscape
	PCMHs	SIM Initiative-wide	Any VBP or APMs
Providers	2,163	2,163	2,163
Practices	328	328	—

Source: Michigan SIM Initiative Quarterly Progress Report for Award Year 2, Report 6.

— = relevant data not provided in the data source; APM = alternative payment model; PCMH = patient-centered medical home; SIM = State Innovation Model; VBP = value-based payment.

F.2.3 Enabling strategies to support health care delivery transformation

Key Results
<ul style="list-style-type: none"> • Support continued for PCMH Initiative participants in the form of newsletters, Webinars, and in-person meetings. • Care managers and care coordinators were required to complete 12 educational hours per year. • SIM participants were successfully onboarded to the MiHIN to support a variety of use cases, including a health provider directory and ADT notifications.

The state supported practice transformation through its Practice Transformation Collaborative, ongoing training, TA opportunities, and required training for care managers and care coordinators. Care coordinators and care managers participating in the SIM Initiative were required to complete 12 hours of a “longitudinal learning activity” per year. At least 6 of these hours had to be completed in a PCMH Initiative-led Webinar or in-person learning session. The remaining

“[The MDHHS] is providing a lot of education and support. They have monthly office hours with all the PCMH practices. There’s a lot of communication and support and...I think there is a lot more care management happening at the practice level and more coordination with the health plans as well.”

—Health plan representative

6 hours could be spent in either a PCMH Initiative-led activity or a training activity led by a Provider Organization. PCMH staff interviewees were generally pleased with the level of support they received from the state to help support practice transformation. Other stakeholders, including health plan representatives, agreed that the TA had a positive impact (*Table F-4*).

Table F-4. Michigan’s progress on practice transformation

Activity	Target population	Key activities	Progress between May 1, 2017, and March 31, 2018
Practice transformation	PCMH initiative practices	Practice Transformation Collaborative	<ul style="list-style-type: none"> Care coordinators and care managers completed 12 hours of learning activities. Practices participating in the PCMH Initiative received a range of TA via Webinars, newsletters, and in-person and virtual summits.
MiHIN	Medicaid health plans and PCMH Initiative practices	Relationship Attribution Management Platform	<ul style="list-style-type: none"> PCMH Initiative participants used the MiHIN to support measurement, reporting, and care management.

MiHIN = Michigan Health Information Network; PCMH = patient-centered medical home; TA = technical assistance.

Practices and payers continued to work on using the MiHIN to support care management and care coordination. By late 2017, all participating PCMHs and Medicaid health plans had received training on using the MiHIN’s Relationship Attribution Management Platform to support care management and care coordination activities. Through the SIM Initiative, PCMHs were required to engage with the MiHIN to support performance measurement and reporting, active care relationship tracking, and the sending and receiving of ADT notifications. Despite progress, CHIRs and PCMHs stakeholders reported that some practices were still struggling to actually use the data made available to them through the MiHIN.

“[The practices] don’t have [ADT notifications] quite right yet from a clinical workflow standpoint. There’s a lot of stuff coming at them—it’s like drinking from the fire hose. The technology is delivering the information, but how you use that technology... is really hard work”
—State official

Interviewees from health plans, CHIRs, and PCMHs noted an increase in the number of patients touched by care coordinators or care managers, and an improved level of coordination between care management staff and other practice staff. One interviewee representing a PCMH commented that it had taken time for care management staff to become integrated in practice, but that by March 2018 the practice had adopted a more “team-based” approach.

F.2.4 Population health

Key Results

- All five CHIRs established hubs to handle referrals and facilitate communication between health care providers and community social service providers. These hubs were at varying levels of maturity.
- SIM funding for CHIR activities was delayed because of issues with the unrestricted request process between the state and CMS.
- Four CHIRs had already participated in the ABL training for systems change in communities or were planning to do so.

The cornerstone of Michigan’s population health strategy was development and implementation of CHIRs—with five CHIRs located throughout the state. As part of the SIM Initiative, each CHIR aimed to develop “Clinical-Community Linkages” based on increased coordination between medical providers and community social service providers through enhanced coordination and communication via one or more “hubs.” *Table F-5* lists each CHIR’s backbone organization and organization type, with descriptions of their respective approaches and status as of March 2018.

Primary care providers and social service agencies used the common SDoH screening tool to identify patient needs and then sent referrals to their CHIR’s hub. During the AR3 analysis period, each CHIR worked on developing a referral mechanism and an electronic system to track service use. Across CHIRs, referrals came into a centralized hub, where they were either addressed or sent to a community-based organization (or “hublet”). State officials reported that full hub implementation had been reached in February 2018. However, this is inconsistent with March 2018 reports from all five CHIRs that they were still in the process of developing and refining technology solutions to enable communication among the PCMHs, the hubs, and social service agencies. All five CHIRs built on existing infrastructure in their region to facilitate the planned communication. CHIR representatives were optimistic that shared technology platforms would help providers and care coordinators “close the loop” on referrals for patients with identified social determinants of health needs.

The volume of referrals into the hub structures remained limited in the AR3 analysis period, because the hub system relied on referrals from screenings in PCMHs and social service agencies, and those had just started. As described earlier in this chapter, not all PCMHs or social service agencies were using the screening tool.

Table F-5. Michigan’s progress on implementation of the Community Health Innovation Regions

CHIR	Backbone organization	Backbone description	Description of hub and clinical community linkages (March 2018 status updates)
Genesee	Greater Flint Health Coalition	Nonprofit healthcare coalition	<ul style="list-style-type: none"> • Hub structure: Central hub and three “specialty hubs” including the Genesee Children’s Healthcare Access Program, the Genesee Health Plan, and the Genesee Health System (community mental health agency). • SDoH screening tool: Delivered by health care providers, provider organizations, and health plans (in pilot phase).
Jackson	Jackson Health Improvement Organization	Improvement Organization founded by local health system	<ul style="list-style-type: none"> • Hub structure: Central hub and social service agencies serving as “hublets.” • SDoH screening tool: All PCMHs and social service agencies will be using SDoH screening tool by mid-2018 (it will also eventually be rolled out to schools).
Livingston – Washtenaw	Center for Healthcare Research and Transformation	Nonprofit research organization housed within the University of Michigan	<ul style="list-style-type: none"> • Hub structure: Central hub and 12 community “hublets,” which include health systems, health plans, housing agencies, and aid organizations. • SDoH screening tool: The CHIR modified the screening tool to include a “social isolation” domain; the screening tool is delivered by PCMHs, health plans, and through a predictive model. • Other details: The Livingston-Washtenaw CHIR developed a predictive model to identify individuals likely to present at the ER.
Muskegon	Health Project (Mercy Health)	Community health project of a local health system	<ul style="list-style-type: none"> • Hub structure: Central hub created under a previous CMS grant. • SDoH screening tool: The CHIR modified the screening tool to assess for childhood trauma; the screening tool was rolled out to all PCMHs in November 2017 (currently Medicaid patients only). • Other details: The Muskegon CHIR restructured its governing body in response to a corrective action issued by the MDHHS.
Northern	Northern Michigan Public Health Alliance	Coalition of health care agencies across 25 counties	<ul style="list-style-type: none"> • Hub structure: Three regionally based hubs, only 10 counties in the CHIR itself. • SDoH screening tool: All patients at all PCMHs being screened (originally, the CHIR piloted the screening tool with only Medicaid patients at six PCMHs). • Other details: The CHIR began discussions with one health plan to consider the feasibility of health plan funding for CHIR activities after the conclusion of the SIM Initiative.

CHIR = Community Health Innovation Region; CMS = Centers for Medicare & Medicaid Services; ER = emergency room; MDHHS = Michigan Department of Health and Human Services; PCMH = patient-centered medical home; SDoH = social determinants of health; SIM = State Innovation Model.

As part of the SIM requirements, each CHIR created a governance structure that included at least 51 percent nonhealth representation. Across CHIRs, these governance structures included representation from government, school systems, health care, public health, social service agencies, health plans, mental health agencies, nonprofit organizations, and other community groups. These groups met monthly to discuss SIM activities. Interviewees from the state and across CHIRs expressed pride in the level of collaboration occurring on the CHIR level. In 2018, the Muskegon CHIR region restructured its hub to satisfy a corrective action plan issued by the MDHHS.

Although some CHIRs (e.g., Northern, Genesee) had been working on systems-level collaboration prior to the SIM Initiative, others found that the SIM Initiative presented a new opportunity to bring together different types of organizations—health providers, social service agencies, payers, and consumer advocates—for the first time. As CHIRs began to think about sustainability, several interviewees commented that they wanted to ensure that the SIM-created collaborative structures would be maintained. The Northern hub had already begun discussions with one local health plan to explore the idea of health plan funding for CHIR activities.

All CHIRs were tasked initially with focusing on high ER utilizers as part of their intervention. Each CHIR approached this in a slightly different way. In Jackson, a PCMH representative reported that the local Provider Organization collaborated with the Medicaid health plans in the region to develop lists of high-risk patients, including patients who frequently accessed the ER. These lists were subsequently shared with practices, which could take steps to contact the “high-risk” patients and devise a patient-centered approach to limit inappropriate ER use. Livingston-Washtenaw developed a predictive model to identify individuals likely to use the ER.

Some CHIRs used CHWs as part of their interventions. At least three CHIRs reported that CHWs played an important role in addressing social determinants of health and connecting patients with local services. As part of the SIM Initiative’s care coordination requirements, some PCMHs and Provider Organizations also employed CHWs. Across these settings, the CHW was becoming more common in Michigan, and several interviewees commented on the need for a reimbursement structure to support CHW work.

The state provided support to the CHIRs through Webinars, conference calls, and the offer of comprehensive training for systems change by using the ABL e Change framework. The ABL e Change framework is designed to help communities more effectively address significant social issues affecting children, youth, and families.⁶ As of March 2018, four CHIRs had either already participated in ABL e Change or were planning to do so within the

⁶ Michigan State University. (n.d.). *About ABL e*. Retrieved from <http://ablechange.msu.edu/index.php/about/our-approach>

following year. The regions that had already participated in ABLLe Change spoke highly of the experience and described it as helpful in refining population health strategies. One CHIR representative said the ABLLe Change framework encouraged CHIRs to take a more active approach to stakeholder engagement.

Several CHIRs reported that they had experienced delays in accessing funds because of the unrestriction request process. Interviewees from three of the five CHIRs expressed frustration that payments had been delayed because of issues in the federal-state unrestriction request process (i.e., the federal process for requesting and releasing SIM grant dollars to be used for CHIR activities). Evidently, costs allowable in past years of SIM implementation had begun to be denied, causing significant reimbursement delays. CHIR staff emphasized that, despite their frustration, this issue had not yet caused them to delay any work—that the state had sent guidance to keep progressing as planned, on the assumption that reimbursement would occur. Despite promises that they would receive payment, CHIR representatives noted that the delays made it extremely difficult to contract with other area organizations.

Sustainability

Stakeholders agreed that health care providers and Medicaid health plans would need to work together to sustain CHIR activities after the SIM Initiative’s conclusion. One CHIR representative emphasized that the CHIRs would need to develop their own regional sustainability plans and not rely on the SIM Initiative to drive conversations around sustainability. Another CHIR representative expressed concern about who should own the data sent to and from the CHIR hubs and how the CHIR governance structures would be organized and financed after the end of the SIM funding. Stakeholders of all types agreed that the work around Clinical-Community Linkages was valuable and hoped for a sustainable path forward to maintain those efforts.

F.3 Implications of Findings/Lessons Learned

The SIM Initiative achieved the following major objectives during the AR3 analysis period:

- Many PCMHs began implementing an SDoH screening tool and developed workflows to support it. Other PCMHs were in the process of adopting the screening tool.
- PCMHs continued to receive PMPM payments to support practice transformation and care coordination via the Medicaid health plans. This process was generally seen to be working smoothly.
- All five CHIRs set up “hubs” to receive referrals and connect individuals with community resources.

- CHIRs developed data sharing systems to electronically track referrals and close feedback loops.
- Four CHIRs participated, or planned to participate, in the ABLe Change training, and those who completed it reported that it had positive impacts on their region's activities to improve population health and equity.
- The state continued to work with the Medicaid health plans around APM development and goal setting.

Based on the SIM implementation experience, stakeholders identified promising practices, remaining challenges, and lessons learned that could be useful for other states pursuing system transformation. These include the following:

- Leveraging Medicaid health plan contracts was an effective way to provide continuity and alignment across care delivery and payment strategies. However, focusing only on Medicaid limited the ability to achieve broad-based payment and delivery reforms.
- Convening under the SIM Initiative allowed for useful, clear communication among stakeholders within each CHIR, enabling groups that did not usually interact an opportunity to work together to pursue population health aims.
- Developing APMs from existing value-based approaches used by Medicaid health plans did not lead to large progress moving up the HCP-LAN framework. The inertia of relying on existing approaches was difficult to overcome.
- Incentivizing practice transformation and care coordination through enhanced funding appeared to be an effective strategy, although funding sustainability looked to be a significant hurdle.
- Promoting the use of CHWs to create Clinical-Community Linkages was an appealing strategy to providers and social service agencies, although the strategy's effectiveness was not yet determined.
- Many primary care practices were open to the use of an SDoH screening tool; Michigan developed a standardized screening tool and successfully collected data from across SIM regions.
- CHIRs expressed frustration with challenges in the unrestriction request process. Although none had needed to delay activities yet, they suggested that ongoing delays in funding would be problematic and could eventually prevent them from carrying out their work as proposed.

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Appendix G: State Innovation Model in Model Test States: New York

Key Results from New York's State Innovation Model Initiative May 2017–March 2018

Strategies, progress, and accomplishments, May 2017–March 2018

- Nearly 750 primary care practices were participating in technical assistance (TA) on Advanced Primary Care (APC) practice transformation by the end of this period.
- New York prepared to switch from its APC care delivery model to a New York State (NYS)-specific version of the National Committee for Quality Assurance's (NCQA's) Patient-Centered Medical Home (NYS PCMH) model. This model is more advanced than NCQA's 2017 PCMH recognition standards as some optional criteria are mandatory in the New York version of the model. The switch took place April 1, 2018.
- Regional multi-payer committees have been formed to work on reaching agreement on payment models to offer targeted small practices to support transformation to the APC (now NCQA's NYS PCMH) model.

Stakeholder response to implemented strategies

- Major SIM stakeholders support the transition to NCQA's NYS PCMH model.
- Some stakeholders are expressing frustration that the state is not using more policy levers to encourage payer support of APC practice transformation.

Remaining challenges

- New York still struggles to get commitment from commercial payers to support APC practices.
- Stakeholders expressed widespread uncertainty about whether the state will reach the goal of shifting 80 percent of care into APC delivery models and value-based payment (VBP) contracts by January 2020.

Sustainability after the SIM award

- Shifting to NCQA's NYS PCMH model will help sustain the SIM practice transformation work because practices that become NCQA certified can maintain that certification after the SIM Initiative ends.
- The switch to NCQA's NYS PCMH model enables state officials to specify what PCMH activities practices must conduct to become NCQA-certified PCMHs in New York.
- Regional multi-payer committees may continue payment model coordination efforts launched under the SIM Initiative.

The New York SIM Initiative began on February 1, 2015. Its central component is to encourage small practices to adopt the PCMH model of care. New York's SIM vision is twofold: (1) for private payers to make new payments to primary care practices that adopt the state's customized version of the PCMH model and (2) for state contractors to provide TA to help practices meet the PCMH milestones.

This updated overview of the New York SIM Initiative is based on analysis of data collected from a site visit interview and focus groups, stakeholder telephone interviews, state document reviews, and state program and evaluation calls between May 1, 2017, and March 31, 2018, the Annual Report (AR)³ analysis period. Further details on the analytic approach are available in *Chapter 1*. Information on the number and types of stakeholders interviewed for the state is in *Table 1-1*. *Figure G-1* depicts the timeline of major New York SIM Initiative and SIM-related activities to date.

G.1 Key State Context and Progress Prior to May 2017

G.1.1 Pre-State Innovation Model health care in New York

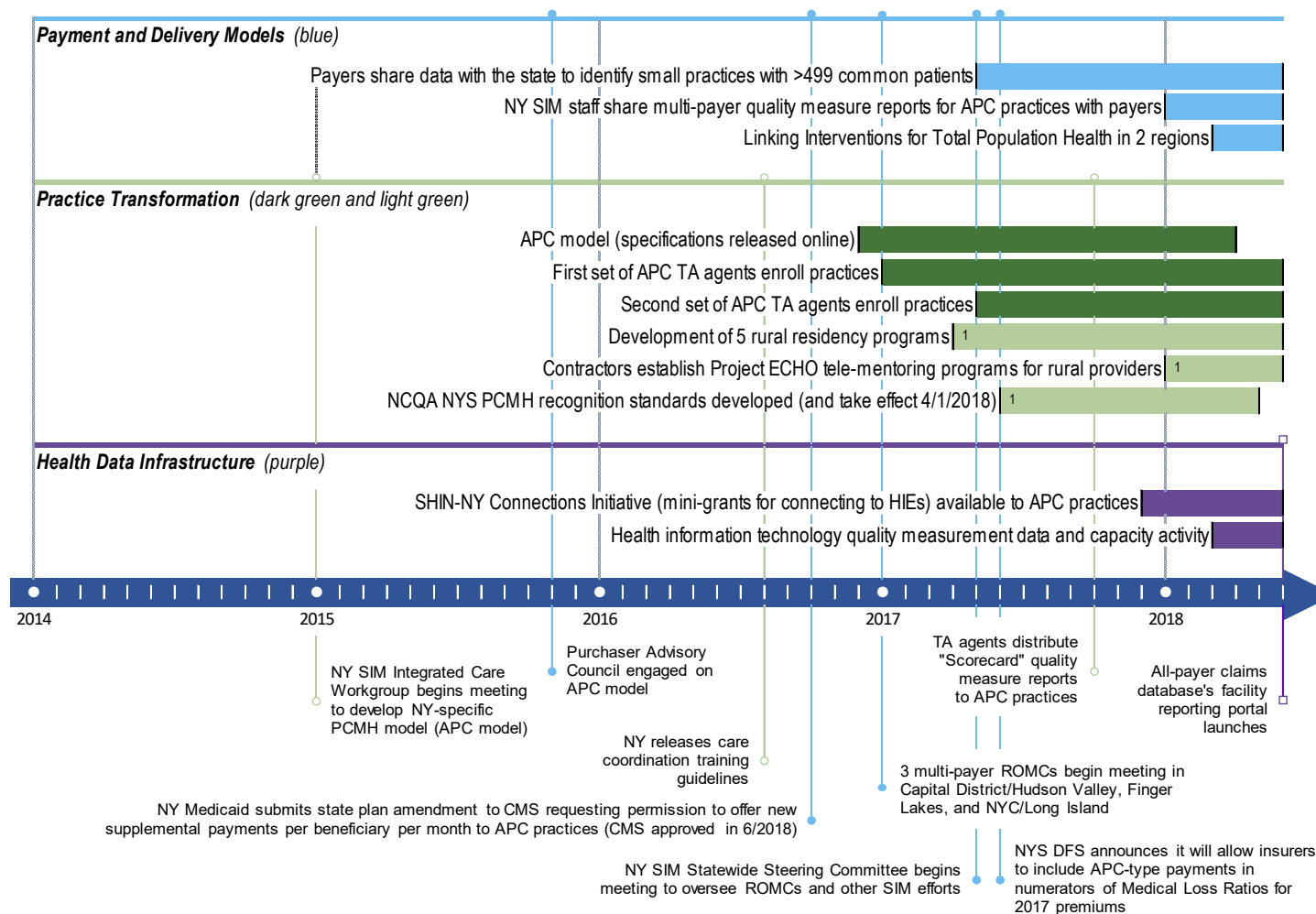
New York’s history of pursuing care delivery and payment transformation initiatives features two particularly influential influences: the multi-payer Adirondack Medical Home Demonstration, which eventually included Medicare as part of CMS’s Multi-payer Advanced Primary Care Practice Demonstration, and a multi-payer initiative in the Capital District-Hudson Valley Region (hereafter, the Capital area), which included Medicare through CMS’s Comprehensive Primary Care Initiative. In addition, the state promoted development of the PCMH model through other initiatives, such as making Medicaid per member per month (PMPM) payments available to practices that become formally recognized as PCMHs by NCQA.¹ Several private payers have also sponsored initiatives aimed at transforming primary care.

A major effort to transform primary care delivery and payment that is contemporaneous with the SIM Initiative 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.² New York is also 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).

¹ NYS Department of Health (NYSDOH). (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/technology/innovation_plan_initiative/pcmh/docs/pcmh_initiative.pdf.

² NYSDOH. (2016, August). *Delivery System Reform Incentive Payment (DSRIP) program*. Retrieved September 14, 2016, from http://www.health.ny.gov/health_care/medicaid/redesign/dsrp/

Figure G-1. Timeline of New York State Innovation Model and State Innovation Model-related activities



G-3

Note: Lighter shades (with ¹) of the same color bars denote similar activities or models.

APC = Advanced Primary Care; CMS = Centers for Medicare & Medicaid Innovation; DFS = Department of Financial Services; ECHO = Extension for Community Healthcare Outcomes; HIE = health information exchange; NCQA = National Committee for Quality Assurance; NY = New York; NYC = New York City; NYS PCMH = New York State Patient-Centered Medical Home; PCMH = patient-centered medical home; ROMC = Regional Oversight and Management Committee; SHIN-NY = Statewide Health Information Network for New York; SIM = State Innovation Model; TA = technical assistance.

G.1.2 State Innovation Model Initiative progress and changes prior to the Annual Report 3 analysis period

Through the SIM Initiative, NYSDOH is working to establish a voluntary multi-payer payment model among commercial payers that would financially incentivize primary care practices to adopt the state’s version of the PCMH model of care. New York’s original approach was to urge payers to commit to making APC payments to support this transformation *statewide*. In a major implementation change in late 2016, however, the state trimmed its approach—focusing instead on convincing payers to make APC payments *in specific geographic regions*. Toward that end, New York established regional committees, called ROMCs. In early 2017, the state began convening ROMCs in three regions of the state, but no private payer agreed to make APC payments prior to the AR3 analysis period.³ In an effort parallel with the SIM Initiative, New York’s Medicaid program endorsed the APC model in a state plan amendment submitted to CMS in late 2016 seeking approval to offer new payments to primary care practices that are APC certified. (New York Medicaid already offers supplemental payments to practices that adopt the NCQA PCMH model of care.) New York also used SIM funds to launch the practice transformation agent (PTA) program to provide coaching and TA to practices interested in adopting the APC model. PTAs began recruiting primary care practices to participate in the APC model; as of May 2017, 100 practices had enrolled in TA to adopt the APC model of care.

G.2 Progress and Accomplishments from New York’s State Innovation Model Initiative, May 2017–March 2018

G.2.1 Delivery models and payment reforms

Key Results
<ul style="list-style-type: none">• SIM-funded PTAs operating across the state enrolled approximately 650 additional primary care practices in TA designed to help practices adopt the APC model of care, bringing the total number of enrolled practices to nearly 750. This level is still well below New York’s enrollment target of 2,400 practices.• Commercial payers participated in newly formed ROMC meetings in three regions of the state. Payers in Albany shared data to aid in identifying small practices to which they could offer new payments.• Regional payers have been more receptive than national payers to offering APC practices new payments. Similarly, payers in more competitive markets have been more receptive than payers in less competitive areas.• New York SIM staff decided to transition from having PTAs certify practices as APCs to having NCQA recognize practices as PCMHs using a New York-specific version of NCQA’s 2017 PCMH standards.• State SIM staff organized PTA trainings to help practices adopt NCQA’s NYS PCMH model.

³ An existing multi-payer committee exists in a fourth region, to coordinate a multi-payer PCMH effort that predates the SIM Initiative.

No commercial payer has committed to make payments supporting transformation, though nearly 750 primary care practices have enrolled in TA. Under New York’s SIM Initiative, practices can receive TA from state-contracted vendors on APC practice transformation (or, starting in April 2018, on NCQA’s NYS PCMH model) (*Table G-1*). Commercial payers met on a regular basis in three regions of the state to discuss the possibility of offering new supplemental payments to practices that adopt the APC model, but none of New York’s 20 payers had formally agreed to make such payments as of March 31, 2018. That said, state officials and payer interviewees maintained that some progress on this front was made, particularly in the Capital area and the NYC metropolitan area (hereafter, the Metro area). Furthermore, officials and payers alike believed payer financial commitment was imminent in the Capital area and noted solid payer progress toward making such a commitment in the Metro area. As two of the most populous areas in New York, these regions combined are home to more than 11 million people.

Table G-1. New York’s progress on delivery system and payment reforms

Activity	Target population	Key activities	Progress between May 1, 2017, and March 31, 2018
New York-specific care delivery model	Primary care practices in New York	Specifying a New York-specific version of the PCMH model of primary care	<ul style="list-style-type: none"> Prepared PTAs to switch from the SIM APC model to a New York-specific version of NCQA’s 2017 PCMH standards (with some elective criteria now required). Starting April 1, 2018, all practices that choose to seek NCQA PCMH recognition in New York will be required to adhere to NCQA’s NYS PCMH standards.
Payer financial support of primary care practice transformation	Primary care practices that adopt the APC model (or, starting April 1, 2018, NCQA’s NYS PCMH model), especially small practices not already in VBP arrangements	Convincing commercial payers to voluntarily start offering new supplemental payments to primary care practices that adopt a New York-specific version of the PCMH model	<ul style="list-style-type: none"> Recently established multi-payer SIM committees in three regions met regularly to consider offering new payments to APC practices. Payers in Albany were reported to be close to unveiling plans to offer new payments to APC practices.

APC = Advanced Primary Care; NCQA = National Committee for Quality Assurance; NYS PCMH = New York State Patient-Centered Medical Home; PCMH = patient-centered medical home; PTA = practice transformation agent; SIM = State Innovation Model; VBP = value-based payment.

Under New York’s regional payer-engagement strategy, three ROMCs were established. Committee meetings of each of the three ROMCs—the Capital area, the Metro area, and the Finger Lakes (Rochester) area⁴—focused in large part on getting payer agreement on payment models to support the APC model. While the exact composition of ROMCs varies by region, attendees generally consisted of a state-contracted ROMC meeting facilitator, area commercial payers, state officials from NYSDOH, and as needed, officials from the NYS DFS, the state’s insurance regulator. ROMC meetings were sometimes also opened up to a wider membership, including APC TA contractors, providers, and consumer advocates.

Each of the three ROMCs was in a different stage of getting payers to commit to the APC model—reflecting in part the local health care market, types of payers in the area, and past experiences of payers working together. Interviewees described payer commitment to the APC model in the Capital area as imminent, with one payer saying Capital ROMC payers were nearly “ready to pull the trigger and roll out a coordinated [APC payment] effort.” Interviewees attributed Capital area progress to two main factors. First, the Capital area payers have a “history of collaboration” through their previous work together on Comprehensive Primary Care Initiative, Comprehensive Primary Care Plus (CPC+), and the Adirondacks Medical Home project, a long-standing multi-payer PCMH initiative in New York. Thus, a “comfort level” already existed among Capital area payers regarding the sharing of information when work started on the APC effort, according to interviewees. Second, all four participating Capital area payers are New York-based plans, without the competing interests and demands that characterize national health plans.

Using different payment approaches, the four payers in the Capital area agreed to focus on small primary care practices that have been largely untouched by the payers’ existing VBP initiatives. The Capital area ROMC began meeting in earnest in summer 2017, starting with payers “brainstorming concepts and collaboration areas for a voluntary multi-payer model... asking where would they [the practices] feel safe.” Given that payers emphatically did not want to give up their existing value-based or accountable care organization (ACO) arrangements, the Capital ROMC worked “underneath” payers’ existing arrangements, reaching an “untouched” segment of Capital area primary care practices to target for the APC model. Highlights of the Capital ROMC’s achievements include the following:

- Capital area payers agreed to share data to identify 180 “smallish” primary care practices in the Capital area that they would encourage to enroll in TA and adopt the APC model. Three main factors accounted for the particular method of practice selection in the payer agreement. First, the chosen practices have largely been untouched by any of the four Capital area payers’ existing VBP arrangements. Second, the chosen practices have too few patients in each of the four payers’ plans

⁴ ROMCs in other areas of New York have not yet been established, but there are plans to do so.

for any single payer to cover enough of a practice's patient panel to compel that practice to transform. Third, 180 practices constitute a large enough group that a coordinated effort might put "enough money on the table" to convince those 180 practices that enrolling in the APC TA and beginning transformation might be worthwhile.

- Capital area payers agreed on a coordinated list of quality metrics to be incorporated into performance-based payment models for enrolled APC practices in the area. The agreed-on metrics are a subset of the 28 core measures the state hopes to eventually include in its APC "Scorecard" quality measure reports for APC practices.
- Capital area payers will not use a uniform payment model for APC practices. Instead, each of the four payers will use its own approach to make APC payments. Each payer will also determine its payment level. One payer, for example, intends to make a risk-adjusted prospective PMPM payment to targeted APC practices. This payer will pay participating practices for up to 12 months to help them transform; when practices have reached a certain level of transformation, the payer will shift them to its existing value-based program. Another Capital ROMC payer, in contrast, was said to be considering making retrospective payments to APC practices based on their quality measure performance.

A flyer jointly developed by the Capital area ROMC payers describing these payers' commitment to financially support the APC model was scheduled for release by participating health plans in early April 2018, just after the end of the AR3 analysis period, to help TA contractors recruit these practices.

Metro area payers followed the Capital area payers' blueprint but on a slower timeline. The Metro area ROMC met consistently over several months and took a path similar to that of the Capital area ROMC. The six participating Metro area payers (estimated to account for approximately 95 percent of the Metro area's commercial market) reached agreement on a subset of APC quality measures they would use as part of their payment models, according to state officials. Further, like the Capital ROMC payers, Metro ROMC payers agreed to share data to identify primary care practices that currently do not hold VBP arrangements with any ROMC-participating plan. Beyond that, the details of the Metro ROMC were still being defined as of the end of the AR3 analysis period.

State officials and other stakeholders acknowledged that getting to this point with the Metro ROMC was no small feat. In the end, NYSDOH brought in DFS officials to attend the Metro ROMC meetings on a regular basis—"the real power behind" getting payers to participate, as one official described it. While DFS has been a partner from the start of the SIM Initiative and continuously engaged, state officials felt that the physical presence of DFS was needed at NYC ROMC meetings—primarily to engage national health insurers, which hold a large part of the commercial market in NYC, but also to signal that DFS supports the APC model and wants it to succeed. One state official said that national insurers posed the question, "Do we really want to

come to the table if DFS is not going to do anything?” The DFS presence at the NYC ROMC meetings not only worked to get payers to participate but also provided an opportunity “to have a dialogue [between payers and the state regulator] in a nonthreatening way,” according to one interviewee.

Payers in the Finger Lakes have made limited progress in advancing their payment approach for the APC model. Interviewees mentioned that the health care market in the Finger Lakes is highly consolidated—two large payers dominate the market, and area physicians are concentrated in two hospital systems that are involved in ACO arrangements. DFS was also brought in and held one-on-one meetings with local payers to talk about the significance of the APC initiative and why it was important for payers to participate. One breakthrough state official highlighted was that a large Finger Lakes payer presented data in a recent ROMC meeting showing only about 60 percent of its members in value-based arrangements, saying that the payer in question was “open and willing” to think about how it could align with the other area payers to bring the rest of its membership into VBP models. Another interviewee commented that finding a way forward in the Finger Lakes area may entail supporting primary care physicians within the existing ACO arrangements.

In focus groups held in NYC, primary care providers in small practices voiced many concerns about VBP arrangements. Although state officials and payers were generally united in their interest in moving toward VBP models that typically reward provider performance on clinical quality measures, providers in the NYC focus groups—who were mostly in small practices—shared several concerns with this type of payment model. They expressed frustration with the many activities they are expected to engage in to generate good enough performance to earn bonuses. As one provider put it, “we have to make sure ... we hit all of these other points. ... It’s kind of stressful in that regard, because you don’t maybe see the patient the same way you normally did.”

Yet another provider argued that models that tie payments to performance on quality measures penalize providers who have noncompliant patients. This provider warned that tying payments to quality could devolve into a situation in which providers decline to accept patients with complex, chronic conditions for fear of being penalized.

“A lot of these regulations or recommendations are made by people in ivory towers who don’t have the practical wherewithal to implement all these things in a primary care office. And some of their demands are far from practical ... they’re asking for quality measures that don’t really give good medical care.” —Provider

Importantly, New York decided to abandon its state-defined and state-administered APC model and transition to NCQA’s 2017 PCMH model but with modified requirements specific to New York (NCQA’s NYS PCMH model). After several months of discussions with state and nonstate SIM stakeholders, New York decided to adopt NCQA’s 2017 PCMH model. On April 1, 2018, New York planned to terminate its APC model and transition APC-enrolled

practices to NCQA’s NYS PCMH 2017 practice recognition standards. Many factors motivated the change, according to state officials. One key development was that the 2017 version of NCQA’s PCMH model had been completely revamped from NCQA’s 2014 model to feature many of the elements of the APC model (e.g., periodic check-ins instead of a one-time pass-fail assessment system, annual reassessments, a requirement that every practice location be certified individually rather than at the organization level); these content changes brought NCQA’s standards more in line with APC’s milestones.

The changes to the NCQA 2014 model were not by coincidence. According to state officials, NCQA actually studied the New York APC model as it developed its 2017 PCMH redesign, including meeting with NYSDOH staff. One interviewee believed that NCQA’s interest in incorporating aspects of the APC model may have been motivated by its interest in maintaining business in New York. With more than 2,500 PCMH practices, New York has by far the most PCMH-recognized practices of any state in the nation.⁵ New York originally created the APC model because it felt that the NCQA 2014 model lacked critical components for truly transforming primary care, a sentiment echoed by several New York payers, according to interviewees. While noting several additional benefits to replacing the APC model (see below), state officials also felt that the change was, as one official described it, “just a different title to it...it’s not a different, higher bar. It’s really what we had set out [with the APC model] for the practices to do.”

NCQA’s 2017 PCMH model became better aligned than the APC model with other primary care transformation taking place in New York’s Medicaid program. Primary care providers participating in Medicaid’s DSRIP waiver were incentivized to adopt NCQA’s PCMH model.⁶ Relying on NCQA’s PCMH model could also help the state “harmonize” with commercial payers and their various lines of business because interviewees reported that payers sometimes require or incentivize practices to become NCQA certified. Interviewees generally expected this harmonization to be welcomed by all practices, but especially small

“It became increasingly clear that NCQA had taken New York State’s potential defection incredibly seriously... [NCQA] really tore through New York State’s Advanced Primary Care model as well as the CPC model when they did their redesign... not just the criteria for the program, but also the way in which the program was administered—with a more continual set of updates, as opposed to a three-year point-to-point process, and I think that was material.”

—ROMC participant

⁵ By comparison, Florida had the second largest number of certified practices (928), followed by North Carolina (895). For more information, visit the following Web site:

<https://reportcards.ncqa.org/#/practices/list?p=22&recognition=Patient-Centered%20Medical%20Home>

⁶ Owing to state budget issues, the level of PCMH incentive payments paid to recognized primary care practices serving Medicaid patients is scheduled to be temporarily reduced for 2 months, from \$7.50 PMPM to \$2.00 PMPM, effective May 1, 2018. The level of incentive payments after June 30, 2018, was not yet determined at the time of our site visit.

ones. Along similar lines, the state’s move to NCQA’s 2017 PCMH model would likely help simplify and reduce provider confusion within New York’s complicated landscape of primary care transformation initiatives because both the SIM Initiative and the state’s Medicaid DSRIP waiver activities will now use NCQA. Interviewees also noted that NCQA recognition enables providers to satisfy some Merit-Based Incentive Payment System (MIPS) and some maintenance-of-certification requirements.

NCQA’s 2017 PCMH model provides sustainability for primary care transformation beyond the end of SIM funding. As several interviewees noted, NCQA has the capability and scale to continue to support transformation after the SIM Initiative ends. Several interviewees also noted that NCQA has name recognition that the APC model does not, which state officials and TA contractors felt will help with practice recruitment into transformation. Payers, too, supported the change—liking the standardization of the NCQA model and viewing NCQA as a more independent practice-validating agent than NYSDOH.

“You in essence need a surveyor recognition staff, for what could theoretically be wildly successful—it could easily be 10,000 to 15,000 primary care physicians. It’s a very large task, and I think the state really realized that they were not necessarily well-positioned to maintain that level of staffing once the SIM [funding] ended, and that by utilizing the NCQA recognition process which is established in the market, there were economies that scaled with that.”

—ROMC participant

Providers in NYC focus groups made comments suggesting that they will welcome the shift to using NCQA’s NYS PCMH model. Further, one provider suggested the state combine the various practice transformation efforts under way into a single initiative:

“They should review all the programs and unify them into one. Remove the duplications. Rename it and have ... one single thing which would be all the Healthcare Effectiveness Data and Information Set (HEDIS) [quality measures], MIPS [Medicare requirements], DSRIP [Medicaid requirements], and APC. ... Everything into one program, which would only look at essential stuff.”

Although New York does not have the ability to combine all of these efforts into a single program, the move to use NCQA’s NYS PCMH standards in the SIM Initiative, DSRIP, and some commercial payers’ programs was in line with this provider’s suggestion.

The NYC provider focus groups also illuminated significant confusion among providers regarding the multiple ongoing health system transformation efforts in the state. Focus group participants repeatedly admitted an inability to differentiate between such programs as DSRIP, CPC+, NCQA’s PCMH recognition standards, and the SIM Initiative. This confusion led one such provider to the following conclusion:

“I think it just illustrates the challenge of this whole process for individual physicians and even for group practices. We don’t even know. We physicians have so many other things to think of. We don’t even know who is showing up for what and what these new abbreviations mean. ... I think it’s a warning that there is something fundamentally wrong about this whole process.”

New York is not simply shifting to NCQA’s standard 2017 PCMH criteria. Instead, the state worked with NCQA to create NCQA’s NYS PCMH recognition standards—the nation’s first state-specific NCQA PCMH model.⁷ Once launched, the NYS PCMH model will be the only NCQA PCMH credential available to primary care practices in NYS. The NYS PCMH model preserves many of the main requirements of the APC model, as noted. To achieve recognition under NCQA’s NYS PCMH model, practices will be required to meet NCQA’s core criteria plus 12 additional criteria that would be “electives” in the regular 2017 PCMH model. These 12 additional criteria—which focus on behavioral health integration, stronger case management, VBP, and health information technology—require such activities as screening for behavioral health issues, using a comprehensive risk-stratification approach to identify patients to target with extra resources, consistently obtaining discharge summaries from hospitals, offering an electronic system that allows for two-way communication to provide timely clinical advice, electronically exchanging information with external entities, and engaging in a VBP contract agreement.

SIM funds will be used to pay practices’ initial fees to apply to become an NCQA NYS PCMH. Practices, however, will be expected to cover annual reassessment fees. In early 2018, APC TA vendors received training from NCQA on NCQA’s NYS PCMH model, as noted. Once the new model is launched, TA vendors will begin working with existing APC enrolled practices to transition them to NCQA’s NYS PCMH model and will continue to recruit new practices.

Sustainability

Officials and nonstate interviewees alike believe the shift from the APC model to NCQA’s new NYS PCMH model will increase the sustainability of New York’s SIM-funded practice transformation efforts. After practices adopt NCQA’s NYS PCMH model with the help of SIM-funded TA agents, there are several reasons to expect these practices to maintain the new practice recognition, even after the SIM Initiative ends. Medicaid already offers practices that have become NCQA PCMHs supplemental PMPMs if they have become NCQA PCMHs, and interviewees reported that commercial payers sometimes require or incentivize practices to obtain NCQA recognition. Additionally, because NCQA enjoys strong brand recognition and was widely adopted by practices in New York before the SIM Initiative

⁷ NCQA offers PCMH PRIME Certification to primary care practices in Massachusetts that are already recognized as NCQA PCMHs and meet additional behavioral health-focused standards. In contrast, NCQA’s NYS PCMH model is the first state-specific version of NCQA’s broader PCMH standards.

began, providers may continue to see value in NCQA certification. Finally, as the most popular PCMH-accrediting organization, NCQA is likely to have staying power beyond the SIM Initiative timeframe, enabling practices to maintain their recognition after the SIM Initiative ends. This would not be possible if the state had followed its original plan to use SIM-funded TA agents to certify practices.

Under its agreement with NCQA, New York will be able to specify NCQA’s NYS PCMH standards even beyond the SIM Initiative timeframe. In addition, an NYSDOH representative has been granted a seat on the NCQA committee that decides what the nationwide PCMH recognition standards will look like.

Several stakeholders felt the ROMCs established as part of the SIM Initiative hold considerable promise for sustaining current transformation efforts and could potentially be used to foster future health care reform activities. One state official described the ROMCs as “just the beginning entity...to build something sustainable like a table where people can come together to discuss” health care topics, such as future population health efforts. As a consequence, in the same official’s view, the ROMCs were “an extremely powerful idea, especially in a state like New York.” Another interviewee observed that ROMCs hold the potential to “look at all-payer options under MACRA” and “push on Medicaid a little bit...on alignment.”

In another sustainability effort, NYSDOH continues to explore ways to incentivize VBP arrangements through partnerships with DFS. Various strategies are being explored—including thinking about establishing minimum levels of primary care spending by commercial insurers, primary care network adequacy, and new expectations attached to its annual premium rate review—to push payers to further engage in value-based care.

G.2.2 Progress toward a preponderance of care in value-based payment and alternative payment models

Key Results
<ul style="list-style-type: none">• Many practices have already adopted the PCMH model through non-SIM efforts, and many payers already use their own VBP arrangements.• Even so, many interviewees believe that the efforts of the SIM Initiative to increase the number of small practices in APC models and the number of payers offering them VBP arrangements are not progressing as quickly as needed to meet preponderance of care goals.• New York’s SIM effort focuses largely on encouraging small practices to transform, which may make it difficult to change the way a preponderance of care is delivered and paid for in the state.

New York made some progress toward its goals of shifting a preponderance of care (80 percent) into APC delivery models and VBP contracts during the AR3 analysis period but may have difficulty moving the needle significantly on these preponderance of care goals by the end of the state’s cooperative agreement in January 2020. Interviewees also expressed confusion about the precise numerators and denominators used to assess the state’s performance on its SIM Initiative preponderance of care goals.

“The timeline is another concern. I’m not sure about the ability to reach the stated goal of 80 percent of the population, 80 percent in value-based purchasing. I still think that that is aspirational... I think there is movement, I’m just not sure it’s at the level and magnitude that people would want if you were going to try to do it in the next two years.”

—Payer

New York increased the number of practices that have signed up to adopt the APC model of care. However, no commercial payers have formally committed to making new payments to APC practices. Once payers in the Capital area ROMC announce their expected payment commitments (see further below) and TA contractors switch to NCQA’s new NYS PCMH standards, interviewees believe even more practices are likely to come on board. The state’s SHIN-NY Connections Initiative, through which APC practices can receive SIM funds to help defray the cost of connecting to an HIE, may also increase the number of practices signing up to adopt the PCMH model of care starting in April 2018. (Practices that attest to signing a participation agreement with a regional health information organization [RHIO] receive \$2,000; once they attest to being able to receive a summary of care record electronically, establish a connection to an RHIO, and contribute all required data elements to the RHIO, the practice receives an additional \$11,000 per connection.)

Despite these encouraging developments, interviewees were not sure if the state would ultimately meet its APC preponderance of care goal under the SIM Initiative. Much depends on the definition of “advanced primary care.” If, for example, practices that had previously obtained recognition as a PCMH through NCQA’s existing standards were counted as having adopted an APC model, one state official thought the goal would be achievable. The case for including these practices in New York’s preponderance of care calculations has been strengthened by the recent move to require all NCQA PCMH practices to recertify using the NCQA NYS PCMH standards, as this state-specific version of NCQA’s standards was developed. Another state official commented that the goal would be easier to achieve if CPC+ practices could also be included because CPC+ is operating in two areas of the state.

Interviewees also mentioned that the state’s APC preponderance of care goal might be more achievable if measured on a regional basis rather than statewide. The degree of penetration of APC models across New York varies widely. For example, many practices have signed up to adopt the APC model of care in the Metro area, and many practices have adopted the NCQA

PCMH model in areas with pre-SIM multi-payer PCMH efforts (e.g., Albany, the Adirondacks). Thus, although the original APC preponderance of care goal was specified as a single statewide measure, several regions of the state might be able to achieve a regionally defined goal.

Interviewees were also unsure about which *payers* were to be included in New York’s VBP preponderance of care goal. One state official reported that Medicaid managed care plans were already reporting that 50–60 percent of their payments were in VBP arrangements, for example, which made this respondent optimistic that New York was on track to meet its VBP goal. Commercial payers interviewed did not seem to be aware of the share of payments flowing through their VBP models, estimating the share of their *enrollees* receiving care from providers in VBP arrangements as in the range of 30–80 percent. New York DFS plans to collect the necessary payer information beginning in Fall 2018, updating the previous analysis that was based on 2013 payer data.⁸

One interviewee’s frustration concerned the state’s reluctance to use its regulatory authority (over commercial plans) or its purchasing power (as the sponsor of both Medicaid and the state’s employee health plan) to incentivize or require insurers to enter into payment models that could help New York meet its SIM preponderance of care goals. At the same time, as noted, interviewees described the Capital area as close to ready to announce that the four commercial payers participating in that region’s ROMC would offer new payments to practices adopting NCQA’s NYS PCMH model—suggesting that additional policy levers may not be needed in the Capital area region, at least.

“The state has enormous potential authority to make things happen—at all, let alone at a faster pace—and yet they’re very reluctant to do it. The state has this regulatory authority both at DOH and the DFS, and it’s the largest purchaser of health care. So, it has the ability to direct the vendors that it purchases health insurance from to add certain elements or do certain things. Yet, the state is reluctant to use that authority.”

—Provider organization

By the end of the AR3 analysis period, no patients had yet been reached, and no providers were participating in a commercial VBP model or APM as part of the SIM Initiative. (However, 802 providers had met enough APC criteria by the end of March 2018, making them eligible for Medicaid Incentive Payment Program payments available through New York’s DSRIP program waiver, which pre-dates the SIM Initiative.) Concurrent with the SIM Initiative, a secular move toward VBP models among public and private payers means that New York may reach its VBP goal, even if only a few payers begin making *new* payments as part of the SIM Initiative. No data were available to quantify this trend. When the state completes its planned collection of information from payers, future reports will include more up-to-date information.

⁸ Catalyst for Payment Reform. (2015). *New York Scorecard and Commercial Payment Reform*. Retrieved from <https://www.catalyze.org/product/2015-new-york-commercial-scorecard/>

G.2.3 Enabling strategies to support health care delivery transformation

Key Results	
•	The bulk of New York’s SIM funds support PTAs who coach small primary care practices on how to adopt a state-specific version of the PCMH model of care (initially, the APC model of care; then, starting on April 1, 2018, NCQA’s NYS PCMH model).
•	The vast majority (80 percent) of the practices that have signed up to receive TA from PTAs are in the NYC and Long Island area, which stakeholders described as a competitive market for providers.
•	The shift to NCQA’s NYS PCMH model was widely expected to make it easier for PTA agents to market their services, yet some providers were projected to drop out of TA because of a perception that NCQA’s standards are more difficult to achieve than APC standards.

The main strategy New York is using to support the APC model is providing TA to primary care practices that have agreed to adopt the model. Indeed, the majority of the state’s SIM funding is being used to pay for contracts with 15 organizations that are coaching practices one-on-one on how to deliver care in the APC model (*Table G-2*). Most of the practices enrolled thus far (75 percent) are small, with one to four providers. Practice enrollment in APC TA, however, is still well below the state’s target of 2,400 practices. While not directly part of APC TA, the state also supported practice transformation by furnishing practices with practice-specific quality measure reports (the Scorecard) and offering mini-grants available to APC practices to offset the cost of connecting to a regional HIE. Given the early stage of adoption of the APC model, interviewees generally did not believe the model had yet had a measurable impact on health care utilization or expenditures in the state.

Table G-2. New York’s progress on enabling strategies to support health care delivery transformation

Activity	Target population	Key activities	Progress between May 1, 2017, and March 31, 2018
Practice transformation	Primary care practices not already receiving PCMH TA through other federally funded efforts (DSRIP, TCPI, CPC+)—especially targeting smaller practices	Enrolling primary care practices in SIM-funded TA to help them adopt the APC model	State-contracted PTAs across the state enrolled 650 additional practices in APC TA, bringing the total number of practices receiving TA to nearly 750—well below the state’s target of enrolling 2,400 practices in TA.

APC = Advanced Primary Care; CPC+ = Comprehensive Primary Care Plus; DSRIP = Delivery System Reform Incentive Payment; PCMH = patient-centered medical home; PTA = practice transformation agent; SIM = State Innovation Model; TA = technical assistance; TCPI = Transforming Clinical Practice Initiative.

The main reason practices gave for declining TA, according to interviewees, was the lack of formal payer commitments to offer new payments to APC practices. As of the end of the AR3 analysis period, TA contractors had only recruited approximately 30–50 percent of their enrollment quotas. Secondary barriers interviewees cited included providers being unfamiliar with the APC model (thus requiring time to convince practices of the merits of this model), transformation fatigue, and the awkward timing of TA contractors’ entry into the field (after many practices had committed to adopting NCQA’s 2014 PCMH standards to meet a DSRIP deadline).

“Until we see the private payers and commercials come on board with this, it’s going to continue to be a challenge. Because the first question from the practices is always, ‘OK, so which payers are participating in this?’”

—Provider organization

The vast majority (80 percent) of enrolled APC practices receiving TA were in the NYC and Long Island area, according to NYSDOH counts from January 2018. This level of enrollment makes sense given that roughly 80 percent of the state’s population is located in these areas. In addition, many large APC TA contractors operate in the city, and interviewees described the provider landscape as competitive. For their part, providers in the two NYC focus groups reported feeling that the PCMH model of care was “the future” and that they needed to adopt it to stay competitive. Focus group providers reported making changes to their clinical practices and procedures, although they were not always sure if the changes were made because of their practice’s participation in APC or the state’s Medicaid DSRIP waiver, which required certain participating practices to adopt the NCQA PCMH or APC models of care, as noted. Examples of changes providers mentioned included increasing how often they conducted particular cancer screenings, administering new risk assessments to patients and using that information to identify patients who need more care management, better integrating behavioral health providers into their primary care practices, and updating practice policies and procedures related to documentation and coding. Other recent changes included starting to make electronic referrals, calling patients to remind them to pursue referrals, and getting patients to file a health care proxy with them specifying who can make care decisions if the patient is incapacitated.

Providers in the NYC focus groups also reported feeling overwhelmed by the numerous Medicare, Medicaid, and commercially sponsored delivery transformation efforts under way and viewed the APC model as a burden. Several described the APC model as duplicative of other programs and complained of already excessive reporting requirements further exacerbated by the expectation that providers adopt the APC model. One provider went as far as describing the new activities practices are expected to perform as part of the APC model as a “disservice” to New York patients and providers because they crowd out the core components of a primary care visit.

Only five percent of practices enrolled in APC TA are in the Albany area, where the presence of CPC+ has limited the number of practices able to enroll in SIM-funded TA. Outside the Capital area and Metro area, the remaining regions of the state together amounted to only 15 percent of enrolled practices. TA contractors in regions without a ROMC and no prospect of multi-payer support for practice transformation had a tougher time convincing practices to adopt the APC model of care.

APC TA contractors were also preparing to pivot from helping practices adopt the APC model to helping them adopt NCQA’s new NYS PCMH model, which required redoing their curriculum and changing their messaging in the field midstream. Several TA contractors noted that they expected minor attrition (two to five percent) of existing APC practices because of the move to NCQA. Interviewees felt that some practices may be scared off for two reasons: (1) the shorter timeframe within which NCQA expects practices to become recognized as a PCMH and (2) some practices perceive NCQA’s standards as more difficult to meet than the APC standards. One TA contractor also reported that NCQA will require more documentation of practice policies and procedures than APC did.

In fall 2017, APC practices received their first multi-payer “Scorecard” (quality measure report), which compared practice-level performance data to state averages on 13 claims-based measures. Providers differed from other stakeholders in their views of the Scorecard’s usefulness. Stakeholders conveyed relatively negative feedback, largely because the data were out of date. Providers were more positive. One provider described the exercise of reviewing their scorecard with a coach as “somewhat helpful.” Others said that reviewing the report “keeps [providers] on [their] toes” and is “important” to their clinic’s successful ongoing operations.

“I think in general, it [the scorecard] was viewed as a very reasonable first step, but not enough. Which is actually the reaction I feel like you always get with quality measurement, which is: people want more data, they want more questions, they want to parse it more finely and it’s sort of where you start the conversation. And I think that’s where we are.”

—ROMC participant

“There hasn’t been a lot of guidance on how we are supposed to use these scorecards. We are getting them and sharing them but it’s like, ‘What’s next?’ or ‘What do you want us to be looking at?’”

—PTA

NYSDOH collected Scorecard data through a voluntary request to NYS’s 25 commercial payers; 23 of those payers responded. The state plans to produce another Scorecard next year. State officials said that they may revise the Scorecard’s format in response to feedback—for example, by changing or dropping certain measures.

Although no APC practices had yet taken up this new benefit, as of February 2018, APC practices could receive mini-grants to connect to a regional HIE. A benefit available to APC practices is funding to help offset the cost of connecting their electronic health records to an HIE. Through the SIM-funded SHIN-NY Connections initiative—launched in February 2018—

APC practices can receive \$2,000 when they sign an agreement with a regional HIE connected to the state's SHIN-NY and another \$11,000 when they connect to that exchange.⁹ Despite the potential benefits from being connected to an HIE, no practices had applied for this funding in the first few months of its availability, possibly because of a lack of awareness among eligible practices, as noted by interviewees. As one interviewee said,

“I just think there’s been a lack of information. I asked whether the [APC TA contractors] were mentioning this [the subsidy] as they approached practices, and I don’t think I got a clear answer. I don’t know whether messaging about its availability got to the organizations that are often relied upon to communicate this information out.”

Another informant thought practices might not understand the benefits that can accrue from connecting to an HIE and that “maybe the state leadership can really get ahead of that with the canned Webinars or tutorials to help the practices understand.” Another informant cited up-front investment costs as a barrier to connecting to an HIE, explaining that some practices might decline to make the up-front investments necessary to connect, despite the availability of after-the-fact reimbursement.

New York continued to work on other enabling strategies during the AR3 analysis period. Efforts included addressing health care workforce issues by drafting and revising state legislation that has not gained much traction in the state legislature thus far and preparing to execute contracts setting up rural residency programs and tele-mentoring programs. By the end of 2018, the state also hopes to hire a train-the-trainer organization to enhance APC TA contractors’ abilities to help practices meet patient engagement requirements in NCQA’s NYS PCMH model of care.

G.2.4 Population health

Limited progress was made during the AR3 analysis period on New York’s SIM population health strategies. The state continued to work through contractual and administrative details with CMS and the Centers for Disease Control and Prevention (CDC) on its planned Linking Interventions for Total Population Health awards, the primary vehicle by which New York hopes to implement its population health work under the SIM Initiative.

⁹ New York eHealth Collaborative. (2018). *SHIN-NY Connections Initiative (SCI)*. Retrieved from https://www.nyehealth.org/nyec16/wp-content/uploads/2018/02/SHIN-NY-Connections-Initiative_013118.pdf

G.3 Implications of Findings/Lessons Learned

The SIM Initiative achieved four major milestones during the AR3 analysis period:

- A new approach for engaging payers was implemented—involving regularly convening commercial payers for *regional* multi-payer meetings instead of statewide meetings to give payers the flexibility to develop SIM payment models that will vary by region.
- Slow but steady progress was made in convincing commercial payers to offer new supplemental payments to practices that adopt a SIM-supported PCMH model of care (originally the APC model, now the NCQA NYS PCMH model) in three regions of the state that established regional multi-payer committees.
- Nearly 650 additional primary care practices were enrolled in PCMH TA, bringing the total number of practices receiving this SIM-funded assistance to nearly 750—an impressive number but still well below the state’s goal of enrolling 2,400 practices.
- The transition from the APC care delivery model to the likely more sustainable NCQA NYS PCMH practice recognition standards was made—a move interviewees widely praised.

Based on the SIM Initiative implementation experience, several opportunities, remaining challenges, and lessons learned may be relevant for other states, as described below.

- Involving the state’s insurance regulator in multi-payer meetings about new payment models has helped encourage New York payers to think seriously about offering these new payments, according to interviewees. However, payers likely would have made firmer commitments by now if the state had used stronger policy levers to encourage payers to make new payments to practices.
- New York has hit upon a blueprint that state officials believe may yield new voluntary payments from participating payers. This approach was first used in the Capital area and is now being applied in the Metro area. Major steps include the following:
 - (1) identifying a common set of quality measures that all payers in a region agree to use in any new VBP models;
 - (2) identifying practices that all payers contract with, which are not already in VBP arrangements; and
 - (3) letting payers develop their own payment models for these targeted practices.
- The presence of multiple concurrent payment and care delivery reforms has caused confusion and exhaustion among New York providers, especially among smaller practices with fewer staff and less infrastructure.
- Providers would prefer the varied efforts being pursued to be consolidated into one effort, with consistent reporting requirements and care delivery expectations.

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Appendix H: State Innovation Model in Model Test States: Ohio

Key Results from Ohio's State Innovation Model Initiative May 2017–March 2018

Strategies, progress, and accomplishments, May 2017–March 2018

- Increased episode of care (EOC) reporting to 43 episodes, with 9 linked to financial incentives.
- Completed the first full year of Ohio Comprehensive Primary Care (OH CPC).
- Made referral reports available to OH CPC practices and principal accountable providers (PAPs).
- State budget cuts delayed both the expansion of OH CPC to non-nationally accredited primary care practices and the creation of practice partnerships.
- Increased OH CPC practice enrollment from 111 to 161 practices.¹

Stakeholder response to implemented strategies

- EOC reports were not widely seen as useful, and incentives were not considered large enough to foster change.
- OH CPC was judged to be moving Ohio health care in a positive direction.
- Alignment with Comprehensive Primary Care Plus (CPC+) was considered a positive factor in moving the system toward value-based payment (VBP).
- Per member per month (PMPM) payments were described as an important tool to support improving care.
- OH CPC implementation was reported as improving communication among Medicaid, Medicaid managed care plans (MCPs), and providers.

Remaining challenges

- Opening OH CPC enrollment to non-nationally accredited practices and engaging small and rural practices that so far appear to have had limited involvement in the SIM Initiative.
- Engaging EOC providers, who may have limited awareness of or paid little attention to the EOC initiative, in transformation.

Sustainability after the SIM award

- Many shareholders expressed concern about whether the SIM Initiative would be sustained after the November 2018 election, given the advent of a new Governor.
- State officials were packaging program materials and budgets to inform the incoming administration as well as increasing staff and staff training to promote SIM knowledge.
- EOC and OH CPC report production was moved from a SIM consultant to a vendor to sustain reporting activities.

¹ In OH CPC, practices are counted by Medicaid billing ID. As of January 2018, there were 161 Medicaid billing IDs among the practices enrolled in OH CPC. After March 2018, one organization participating in OH CPC consolidated separate Medicaid billing IDs into a single ID, which reduced the total number of OH CPC practices to 145.

Ohio's SIM Initiative began on February 1, 2015. SIM Initiative leaders in the state intended to use the SIM award to enhance primary care and VBP models in partnership with commercial payers. To accomplish its goals, the state focused its SIM Initiative on designing and implementing patient-centered medical homes (PCMHs) and EOCs.

This updated overview of the Ohio SIM Initiative is based on analysis of data collected from site visits, stakeholder telephone interviews, state document reviews, and state program and evaluation calls between May 1, 2017, and March 31, 2018, the Annual Report (AR)3 analysis period. Further details on the analytic approach are available in *Chapter 1*. Information on number and types of stakeholders interviewed for the state is in *Table 1-1*. *Figure H-1* depicts the timeline of major Ohio SIM and SIM-related activities to date.

H.1 Key State Context and Progress Prior to May 2017

H.1.1 Pre-State Innovation Model health care in Ohio

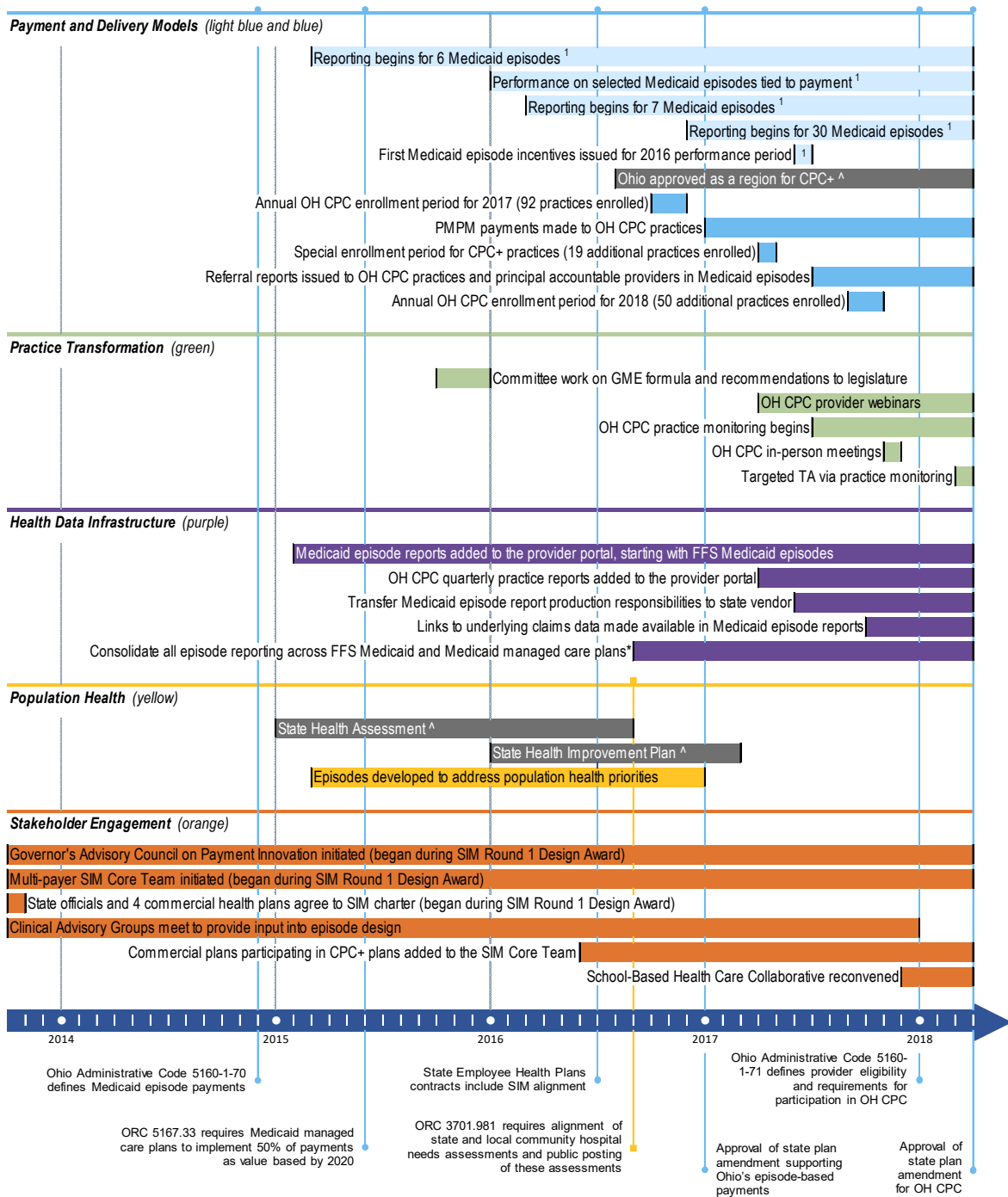
Ohio's pre-SIM population and health care environment presented several challenges. The state featured a highly competitive market (with no health insurer covering more than 20 percent). At the same time, large health systems in major markets dominated in a fee-for-service (FFS) health care system. Ohio combines these market characteristics with a significant rural population in the Appalachian region that has unique health and health care challenges.

H.1.2 State Innovation Model Initiative progress and changes prior to the Annual Report 3 analysis period

Under the leadership of the Governor and his Office of Health Transformation (OHT), Ohio's approaches to health care transformation were initiated prior to, but further developed and implemented under, the SIM Initiative. Ohio's primary goal for SIM-supported payment reform is for 80 percent to 90 percent of all residents to be in a VBP model and 50 percent to 60 percent of the state's medical spending to be value-based within 5 years. Achieving this goal required voluntary buy-in by private sector stakeholders because the Governor was committed to nonregulatory approaches to health care transformation for non-Medicaid providers and payers. To move toward VBP approaches, Ohio used SIM funding to implement an EOC program and OH CPC, a PCMH model, in Medicaid.

Ohio's EOC program is a retrospective payment model that seeks to encourage appropriate, efficient, and patient-centered care by holding a single provider or entity—a PAP—responsible for all health care services related to a given condition or procedure. Providers are subject to both positive and negative payment incentives, depending on their respective performance on costs and quality metrics. Provider performance on episode costs and quality metrics is summarized in episode reports made available to PAPs. Medicaid mandates provider participation via Ohio Administrative Rule and also requires its MCPs to implement the EOC payment system without variation.

Figure H-1. Timeline of Ohio State Innovation Model and State Innovation Model-related activities



COPD = chronic obstructive pulmonary disease; CPC = Comprehensive Primary Care; CPC+ = Comprehensive Primary Care Plus; FFS = fee for service; GME = graduate medical education; OH CPC = Ohio Comprehensive Primary Care; ORC = Ohio Revised Code; PMPM = per member per month; SIM = State Innovation Model; TA = technical assistance.

Notes: Gray bars (with ^) denote that the items are not SIM activities or policies but are important for context. Lighter shades (with ¹) of the same color bars denote similar activities or models. An asterisk (*) denotes that perinatal, COPD, and asthma episodes were previously produced at the Medicaid plan level.

The goals of the OH CPC program are to improve health outcomes, increase quality, and reduce spending through care coordination by primary care providers. Participating practices receive prospective PMPM payments and may be eligible for shared savings tied to quality and cost goals for their attributed Medicaid populations. Ohio CPC is a voluntary program for providers, and MCPs are required to implement the program without variation.

Ohio has worked to engage payers beyond Medicaid. Four commercial insurers had pledged to align with SIM strategies, as defined in a charter they helped develop during Ohio’s SIM Design Award. The state employee health plan (SEHP) contracts required alignment with the SIM Initiative but with no specific methods for accomplishing such alignment.

Prior to the AR3 analysis period, Ohio accelerated statewide implementation of both EOCs and OH CPC relative to initial phase-in plans. Announcement of the federal CPC+ program resulted in a delay in finalizing quality measures as the OH CPC program was being launched.

The updates that follow discuss activities that took place during the AR3 analysis period (May 1, 2017–March 31, 2018).

H.2 Progress and Accomplishments from Ohio’s State Innovation Model Initiative, May 2017–March 2018

H.2.1 Delivery models and payment reforms

Key Results
<ul style="list-style-type: none">• Ohio reported on a total of 43 episodes and increased the number of episodes linked to financial incentives from 3 to 9.• Given changes in the process for input in developing some episodes, the state convened in-person sessions to enable provider feedback on those episodes.• Legislative funding cuts led to a year’s delay in expanding OH CPC to practices without national PCMH accreditation and in creating practice partnerships.

The SIM Initiative continued to make progress by increasing the number of episodes with reporting and with payments and expanding enrollment in the OH CPC program—which finished its first full year (*Table H-1*). Many stakeholders reported positive experiences with OH CPC and were optimistic about the future of health care in Ohio. However, funding issues caused delay in opening OH CPC to non-nationally accredited practices.

Table H-1. Ohio’s progress on delivery system and payment reforms

Activity	Target population	Key activities	Progress between May 1, 2017, and March 31, 2018
EOCs	Medicaid members (excluding Medicare-Medicaid beneficiaries and certain other limited coverage groups) Specialists or facilities, depending on episode type	Provide EOC reports for PAPs Provide positive and negative financial incentives based on cost and quality	<ul style="list-style-type: none"> Generated reports for 43 episodes. Issued incentives for 3 EOCs; performance period began for another 6 EOCs tied to payment on January 1, 2017 and ended on December 31, 2017. Consolidated reports for asthma, COPD, and perinatal episodes across Medicaid plans. Transitioned reporting for 13 EOCs to ongoing state vendor.
OH CPC	Medicaid members (excluding Medicare-Medicaid beneficiaries and certain limited-eligibility groups) Primary care practices enrolled in OH CPC	Provide PMPM payments and shared savings to primary care practices Provide reports on health care cost and quality Provide referral reports to inform specialist referrals	<ul style="list-style-type: none"> Completed first full year. Participating practices grew from 111 to 161. Delayed expanding enrollment to practices without national PCMH accreditation until 2019. Delayed practice partnerships until 2019. Initiated practice monitoring. Issued referral reports on 3 EOCs to OH CPCs and PAPs. Began planning school health initiative to foster practices’ patient engagement with school-aged children and caretakers.

COPD = chronic obstructive pulmonary disease; EOC = episode of care; OH CPC = Ohio Comprehensive Primary Care; PAP = principal accountable provider; PCMH = patient-centered medical home; PMPM = per member per month.

Episodes of care

The Ohio SIM Initiative launched new episodes, distributed episode-related incentives for the first time, updated the episode reporting process, disseminated the first referral reports, transferred reporting responsibilities for 13 episodes to a different contractor, and began to negotiate with CMS about including EOCs in the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act of 2015 (MACRA) Quality Payment Program (QPP). Four commercial payers that agreed to align with the SIM Initiative continued to run their own episode reporting programs.

Ohio reported on a total of 43 episodes and increased the number of episodes linked to financial incentives from 3 to 9. In September 2017, Ohio disseminated final episode reports for the 2016 episode performance period. FFS Medicaid and MCPs distributed payments and losses for the first three incentives-linked episodes shortly thereafter. Ohio reported that Medicaid plans distributed \$2.1 million in positive incentives and \$1.8 million in negative incentives for the three episodes.

Ohio updated the episode reporting process and introduced new referral reports. During the AR3 analysis period, Ohio consolidated separate payers' episode reports for asthma exacerbation, chronic obstructive pulmonary disease (COPD) exacerbation, and perinatal into online reports that combined data from all MCPs and FFS Medicaid. These reports included links to the claims data used to generate the reports and were posted on Ohio Medicaid's Web-based provider portal. Ohio also launched referral reports for asthma exacerbation, COPD exacerbation, and perinatal episodes, which compared performance on cost and quality metrics across PAPs. On the other hand, episode reports did not include these cross-provider comparisons. Ohio planned to increase the number of episodes included in referral reporting as more episodes are reported and tied to payment. Although the main objective of the referral reports was to provide information about PAP quality and cost to OH CPC practices, Ohio also provided referral reports to PAPs initially, so the PAPs would know what information was being shared with CPC practices. The state decided to continue sharing the reports with PAPs to enable them to see their performance compared with that of other PAPs.

Despite the pace of Medicaid EOC implementation, stakeholders continued to report that many providers—particularly small practices—were either unaware of or did not review EOC reports. One MCP representative indicated that many providers in the MCP's network were surprised to receive a negative financial

“Many providers were caught off guard by owing us some sort of risk payment based on their episode performance, which shows they were not paying attention to the reports we were sending them every single quarter for years.”

—Medicaid MCP representative

adjustment through the EOC program. The same MCP representative also noted that small practices were most likely to resist the EOC concept. Both the MCP representative and a state official noted that large health systems were more engaged in EOCs and more likely to review episode reports. The state official further noted that large health systems used EOC reports to evaluate provider performance. In response to limited provider interest in the episode reports, one provider suggested that in-person outreach to providers could help providers make better use of episode data. Another provider suggested publicizing the impact of episodes, noting that positive results for EOCs would help the program “gain traction and credibility.”

Several providers voiced concerns about the data the episode reports presented.

Two provider interviewees indicated that electronic health record data provided a more accurate assessment of health care quality than did administrative claims (the data source for Ohio's Medicaid EOCs). One provider expressed skepticism about an episode report he received in which “the low end of the scale was \$8” for a complicated, expensive condition. The provider suggested that this \$8 estimate indicated the data had not been appropriately analyzed and interpreted. Based on concerns about the data in episode report, this provider concluded that the episode reports did not provide actionable information.

Providers also reported that the financial incentives associated with the episodes program were not sufficient to incentivize changes in practice. Two provider interviewees indicated that the payments and penalties for EOCs were not enough to make providers focus on EOCs. One provider indicated that the incentives were too small to encourage providers to invest in practice transformation. The provider also added that the retrospective design of the episode incentives was an issue for providers. He suggested that other providers would be hesitant to make an investment if they were unlikely to see a reward for that investment until 2 years later.

“I would be hesitant to alter anything about my business practice or clinical practice based on the information these episodes provide. I get better information from private payers regarding the overall cost of care in terms of episodes than I do from these.”

—Provider

Four commercial payers continued their own EOC initiatives that aligned with EOCs for Ohio Medicaid. Each of these payers reported on between three and eight episodes—such as asthma, acute percutaneous coronary intervention, and perinatal—that are Ohio Medicaid EOCs. One payer also implemented limited testing of payments based on episode performance. Ohio noted that three of the four payers used “relevant quality metrics according to Ohio episode definitions,” while one payer used a more limited set of quality measures. Three of the four payers provided episode reports to a limited number of providers (between 25 and 185). The commercial episode reporting initiatives were ongoing from prior years. Ohio’s SEHP also took initial steps to align with the SIM Initiative but has not implemented SIM-aligned episode reporting or payment activities with its three commercial plans. These plans are among the commercial plans that have agreed to align with the SIM Initiative for their commercial populations.

Given changes in the process for input into development of certain episodes, the state convened in-person sessions to enable provider feedback on those episodes. For most episodes developed during 2017, the state primarily used online and telephone methods to gather input into design, which was a departure from the in-person clinical advisory groups used in prior years. PAs for episodes developed without in-person input were engaged in three reactive, clinical feedback sessions in winter 2017. These sessions gathered feedback on 18 episodes from about a dozen specialists practicing in different areas of the state.

To sustain EOCs post-SIM reporting, Ohio began to transfer episode report production to a long-term vendor and to negotiate with CMS to include EOCs as part of MACRA’s QPP. The vendor began producing reports for 13 episodes and will assume responsibility for all episode reports during 2018. Ohio also began working with CMS to allow providers to count participation in EOCs toward participation in a MACRA-approved alternative payment model. Ohio coordinated with Tennessee, another state implementing EOCs through its SIM Initiative, in its CMS negotiations. Ohio state officials believed that making EOCs part of

MACRA’s QPP would increase provider support of the EOC program, and in turn, make EOCs more sustainable.

Ohio Comprehensive Primary Care

OH CPC was clearly established as a well-recognized Medicaid program at the time of the AR3 analysis period site visit, and stakeholders generally viewed OH CPC positively. These perceptions stood in contrast to early 2017, during the AR2 analysis period, when OH CPC had just been implemented. At that time stakeholders shared concern that providers were confusing OH CPC with the federal CPC+. During the AR3 analysis period, at least one payer viewed OH CPC’s efforts to align with the federal CPC+ as an important accomplishment. He noted that the state was “getting that snowball effect that ‘Hey, this can work!’ It’s a more energized pro-coordinated care attitude than 5 years ago. If it was just CPC+ and not the SIM program, or vice versa, we might not have had that.” This recognition and support for OH CPC stands in contrast to many stakeholders’ limited knowledge of EOCs.

Most OH CPC practices already had sophisticated infrastructure and support from health systems or external agencies and organizations.

The large OH CPC practices that dominated OH CPC enrollment as of mid-2017 generally appeared to have infrastructure (e.g., electronic health records, dedicated data analytics staff, internal performance programs) or to have some of these tools and other resources available through the support of other agencies, institutions, and organizations, or both. Federally Qualified Health Centers (FQHCs), which constituted just over half of the enrolled practices in mid-2017, had substantial federally supported infrastructure, as well as state and national associations that provided support in improving care. In Ohio, monthly calls and an annual meeting the state association hosted were

“We are happy to pay them [sophisticated practices] a higher PMPM and give them a performance bonus, because they were already generating results in the system.”

—State official

“The Ohio CPC program is a great place for us to train my practices about value-based payment and to move into the value-based payment world. They weren’t so motivated to do that before.... It is forcing them to modernize their practices and think population health management.”

—Provider representative

vehicles for discussing OH CPC and its implications. For example, Ohio FQHCs changed their coding methods to obtain PMPMs they believed reflected the appropriate level of risk in their patient populations. Hospital-affiliated CPC practices, making up nearly one third of the 2017 enrolled practices, also have, or have access to, the sophisticated infrastructure and resources of hospitals and health systems. Many stakeholders, however, continued to express concern that smaller and more

rural practices would not be able to meet the CPC requirements, given that many lack the kind of infrastructure and organizational supports that most current, nationally accredited OH CPC practices have.

Some evidence indicates that OH CPC made a difference in health care delivery by using PMPM payments to hire new staff or make other investments. OH CPC payments, coupled with revenue from Medicaid expansion in Ohio, reportedly allowed most, if not all, FQHCs to hire and sustain additional staff (e.g., case managers, social workers, patient navigators). A large group primary care practice also hired staff to address behavioral health and social determinants of health, with a focus on pediatric patients (who make up a sizable portion of the Medicaid population). One provider noted that receiving the PMPMs up front gave practices the flexibility to make investments when needed, rather than having to wait for later payment. Some providers and payers indicated that, while PMPM payments were enough to keep practices interested in OH CPC, the amounts might not be sufficient to support extensive practice transformation and care coordination.

“PMPM gets everyone in the game... and helps them afford and get past excuses of not hiring care coordinators. I think the level of funding is still paltry...If we really want to do care coordination, it will cost more than \$3.50 per patient per month for a Medicaid population.”

—Provider representative

State officials noted that providers viewed PMPMs as a way of making up for relatively low Medicaid reimbursement rates. One of these officials also saw PMPMs as a way for the state to reward practices for the care coordination work already occurring prior to OH CPC.

OH CPC created some new challenges for plans and practices. Attribution, in particular, raised concerns and opportunities. Some providers were concerned that some patients in their practices were not attributed to them. Some practices used the attributions as an opportunity to reach out to patients who were high risk but had unmet health care needs. Other practices asked patients to call MCPs to “self-attribute” to a practice. Stakeholders noted a lack of clarity around how to divide care coordination responsibilities between payers and providers, indicating they could use more state guidance in this area. Providers also expressed concern about the additional responsibilities the SIM Initiative placed on MCPs—with some plans already having difficulty with non-SIM functions, such as paying claims in a timely manner. Noted one provider representative, “...I’m not going to think about practice transformation if I can’t get a claim paid for 6 months.”

Several stakeholders noted that OH CPC improved communication and coordination among Medicaid, MCPs, and providers. This coordination represented a change from the pre-SIM period. Increased communication and coordination occurred particularly around attribution, care coordination, and reporting—between providers and MCPs, as well as between the state and FFS providers. Providers worked with plans to improve the attribution process. Plans and providers also discussed dividing up and transferring care management responsibilities.

“We are asking the managed care plans to play a major role in providing support and collaboration with the practices. That is something that is new to the plans as well.... We are asking the plans to do business in a way that is different.”

—State official

Although some communication continued to occur, primary care providers experienced a decline in engagement, compared with the AR2 analysis period when advisory groups were active. Noted one primary care practice representative, “I am disappointed that the committee seems to be involved less. Initially, there were a lot of stakeholders [engaged]. There needs to be a focus on how you reach out to the independent practices and how you engage them to create a common goal and vision.”

OH CPC faced a significant challenge when the state legislature moved to eliminate the program and its funding. OH CPC was ultimately retained with a reduced budget, leading SIM officials to delay two OH CPC activities planned for 2018: (1) expanding OH CPC enrollment to practices not nationally accredited as PCMHs and (2) implementing practice partnerships that would allow smaller practices to join to meet the threshold of 5,000 Medicaid lives needed to participate in shared savings. Ohio officials eventually identified funding within the Medicaid budget to offset some of the budget cut and are now moving forward with a plan to expand eligibility to non-nationally accredited practices and implement practice partnerships in 2019. State officials and other stakeholders thought a lesson learned was the need to better inform the legislature about OH CPC and its link to improving care and curbing costs.

As in the AR2 analysis period, all stakeholders experienced a decline in information and engagement, compared to the SIM Initiative’s design phases. Plans and providers generally reported that the state was more focused on “getting the word out,” rather than seeking input or feedback. Consumer and population health stakeholders reported that the state had informed and engaged them in design but not in implementation, although these groups were optimistic about, and believed that they could be helpful in, efforts to sustain SIM activities. Some consumer-oriented stakeholders were concerned whether the strategies were reaching the most vulnerable Medicaid recipients, such as refugees, racial and ethnic minorities, residents of rural areas, or people with disabilities.

New and complementary initiatives

Ohio added development of a new school health initiative to the SIM Initiative at the end of 2017, intended to facilitate patient engagement and be linked to OH CPC. In January 2018, the state reconvened the School-Based Advisory Work Group to assist in planning, with design decisions intended to be finalized by March 2018. One stakeholder participating in the advisory group was positive about the prospects for addressing the intersections of health and education.

H.2.2 Progress toward a preponderance of care in value-based payment and alternative payment models

Key Results

- Stakeholders believed meeting the preponderance of care goal before the end of the SIM Initiative was unlikely.
- Stakeholders saw budget cuts and administration changes as among the potential obstacles to reaching the preponderance of care goal.
- Approximately 42.6 percent of targeted Medicaid members were eligible for an EOC in second quarter 2017, representing a 31.2 percentage point increase from second quarter 2016.

State officials suggested—and other stakeholders stated directly—that although the groundwork was laid, preponderance of care targets might not be reached until after the end of the SIM award period. Ohio is currently reporting preponderance of care data only for Medicaid. Depending on definitions, stakeholders thought that the voluntary nature of commercial payer alignment, limited SEHP alignment, and potential challenges to engaging small and rural practices in OH CPC might combine to prevent Ohio from reaching the preponderance of care goal by the end of the SIM Initiative. State officials were uncertain, for example, whether commercial plan activities counted toward reaching preponderance of care because the PCMH and EOC initiatives of commercial plans were not designed the same way as those for Ohio Medicaid. In addition, although the SEHP took initial steps to move toward VBP approaches, the SEHP did not require participating plans to implement SIM payment models. Furthermore, as a provider noted, “It is not hard to get bigger groups and systems. Reaching the 80 percent will be dependent on the smaller practices.”

Table H-2 presents the extent to which SIM payment and health care delivery models reached Ohio’s Medicaid population as of third quarter 2017, the state’s latest figures reported in their Award Year 3, Report 4 progress report to CMMI.² Approximately 42.6 percent of targeted Medicaid members were eligible for an EOC in that quarter, representing a 31.2 percentage point increase from second quarter 2016. Nearly one third of Ohio Medicaid members were attributed to practices participating in OH CPC. Because the first OH CPC practices only began in January 2017, this was the first time the state is reporting these data.

² These data values were not verified by CMMI. Thus, the RTI team cannot attest to their accuracy.

Table H-2. Population reached by a value-based payment or alternative payment model in Ohio, latest reported figures as of second and third quarter 2017^{1,2}

Payer type	SIM models			Landscape
	PCMHs	EOC payment models	SIM Initiative-wide	Any VBP or APMs
Medicaid	836,026 ¹ (32.5%)	1,096,792 ² (42.6%)	— ³	— ³

Source: Ohio Metric Template for Award Year 3, Report 4.

— = relevant data not provided in the data source; APM = alternative payment model; EOC = episode of care; PCMH = patient-centered medical home; SIM = State Innovation Model; VBP = value-based payment.

¹ PCMH participation is current as of third quarter 2017.

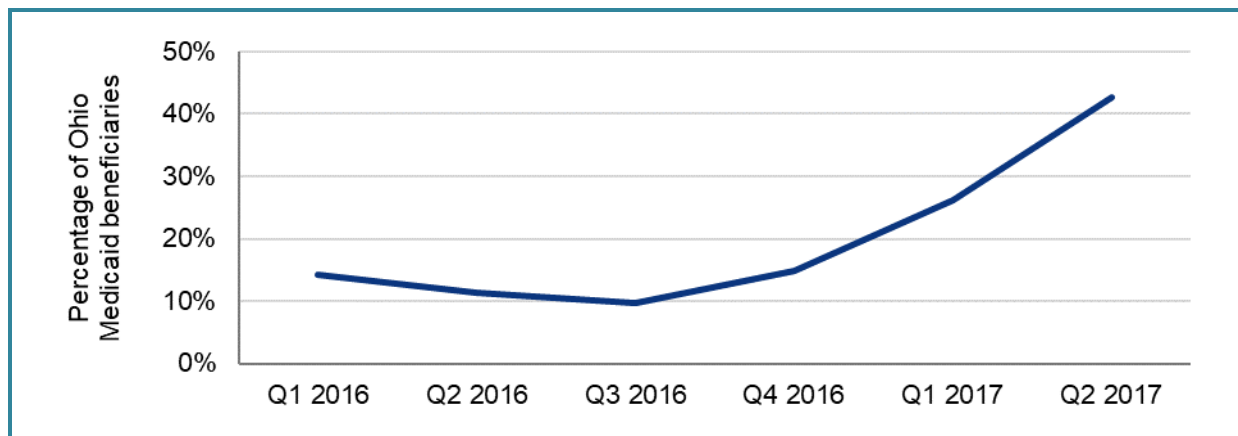
² EOC participation is current as of second quarter 2017.

³ A total was submitted for 2016 but is not yet available for 2017.

Note: The denominator is the total Medicaid-enrolled population minus beneficiaries with eligibility for both Medicare and Medicaid and certain other targeted populations without full Medicaid benefits (2,575,786).

Figure H-2 presents the quarterly trend in Medicaid beneficiaries reached by the EOC initiative (those whose providers were included in episode reporting, with some of these episodes tied to payment) from Award Year 1, Report 1 (2016) through Award Year 3, Report 4 (2017). As more episodes launched, the percentage of the Medicaid population included in an episode trended upward, from approximately 15 percent in first quarter 2016, to more than 40 percent five quarters later.³

Figure H-2. Quarterly trend in the Medicaid population reached by episode of care reporting or payment in Ohio, latest reported figures as of second quarter 2017



Source: Ohio Metric Template for Award Year 3, Report 4.

Q = Quarter.

³ Because OH CPC launched in January 2017, this figure does not include trends in OH CPC quarterly participation data.

Table H-3 presents the extent to which Ohio’s providers were participating in SIM payment and health care delivery models. As of second quarter 2017, 76.9 percent of Ohio’s Medicaid-participating providers eligible for the EOC initiative received EOC reports. This share represented an increase of 2.9 percentage points since second quarter 2016. Twenty-eight percent of Ohio’s EOC-eligible Medicaid providers reported enough episodes (five or more) to be eligible for EOC incentives, an 8.9 percentage point decrease since Award Year 1, second quarter. This decrease resulted from faster growth in the number of EOC-eligible Medicaid providers, relative to the number of EOC-eligible Medicaid providers also eligible for EOC incentives.

Table H-3. Providers participating in a value-based payment or alternative payment model in Ohio, latest reported figures as of second and third quarter 2017

Provider type	SIM models			
	PCMHs	EOC payment models	SIM Initiative-wide	Any VBP or APMs
Providers ¹	13,463 ² (37.2%)	13,292 ³ (76.9%) 4,839 ⁴ (28%)	— ⁵	— ⁵
Practices	111 ² (59.7%)	—	—	—

Source: Ohio Metric Template for Award Year 3, Report 4.

— = relevant data not provided in the data source; APM = alternative payment model; EOC = episode of care; OH CPC = Ohio Comprehensive Primary Care; PCMH = patient-centered medical home; SIM = State Innovation Model; VBP = value-based payment.

¹ Unique providers are counted using Medicaid provider billing identifiers. PCHM participation is current as of third quarter 2017.

² PCMH participation is current as of third quarter 2017.

³ Eligible for EOC reporting. EOC participation is current as of second quarter 2017.

⁴ Eligible for EOC payments. EOC participation is current as of second quarter 2017.

⁵ A total was submitted for 2016 but is not yet available for 2017.

Note: The denominator for PCMHs is total number of providers (36,225) and practices (186) targeted for inclusion in the OH CPC initiative. The denominator for EOC is total number of providers targeted for inclusion in episode-based payments; it includes all providers with the presence of at least one valid or nonvalid episode (17,281).

Ohio set a target of 186 practices for inclusion in the OH CPC initiative. As of third quarter 2017, 111 practices were participating in OH CPC, representing 59.7 percent of the target. They also reported reaching 37.2 percent of the providers targeted for inclusion in OH CPC.

H.2.3 Enabling strategies to support health care delivery transformation

Key Results

- Referral reports were created, and reports for three episodes previously reported at the Medicaid plan level were consolidated and moved online by the state’s data systems.
- For the first time, the state held in-person learning sessions with OH CPC providers to discuss best practices and provide feedback on the OH CPC program.
- The SIM Initiative launched OH CPC practice monitoring and offered TA to practices identified as needing improvement.

Ohio continued to engage in activities related to quality measure alignment, health information technology (health IT) and data analysis infrastructure, and practice transformation and workforce development. Quality measure alignment continued to be part of the process of episode development, with efforts to align with related state and national measures occurring as new episodes were developed. No new activity on measure alignment for OH CPC occurred during the AR3 analysis period. In terms of data analysis infrastructure, additional claims-based reports for EOC and OH CPC initiatives were produced and transitioned online. Providers were still learning how to interpret and use these reports. Practice transformation activities included targeting practices for TA on activity requirements as part of monitoring the OH CPC initiative (*Table H-4*).

Quality measure alignment

As part of their contracts with Ohio Medicaid, Medicaid MCPs are required to align on quality and cost measures for EOCs and OH CPC—with alignment addressed as each new episode is developed. The alignment requirement did not change during the AR3 analysis period. Commercial plans continued to voluntarily align some of their quality measures with those for the SIM Initiative.

Health information technology and data analysis infrastructure

Ohio consolidated reports across MCPs and FFS Medicaid. Quality and efficiency metrics reports for asthma exacerbation, COPD exacerbation, and perinatal episodes began to be produced across all Medicaid plans and FFS during the AR3 analysis period, rather than separately as had previously been the case. The consolidated reports were posted on the Medicaid provider portal, with links to the underlying data. One provider described this process as a major improvement, referring to receiving different episode reports from multiple plans as a “disaster.” OH CPC reports were consolidated from the launch of the program in 2017.

Table H-4. Ohio’s progress on enabling strategies to support health care delivery transformation

Activity	Target population	Key activities	Progress between May 1, 2017, and March 31, 2018
Quality measure alignment	Commercial and Medicaid payers	Alignment of quality and cost measures for EOCs and for OH CPC program across FFS Medicaid and MCPs Voluntary alignment of quality and cost measures between four commercial plans and Medicaid	New episode development continued to include efforts to align quality measures
Health IT and data analysis infrastructure	Providers participating in OH CPC and EOC	Production of reports for OH CPC and EOC	Enabled EOC reports for asthma exacerbation, COPD exacerbation, and perinatal episodes across Medicaid plans and FFS to be consolidated online and referral reports to be added online
Practice transformation and workforce development	Providers participating in OH CPC	Information sessions for practices participating in OH CPC TA connected to practice monitoring	<ul style="list-style-type: none"> • Webinars on OH CPC program components • Two days of in-person learning sessions for OH CPC practices • Identification of practices needing TA to meet activity requirements

COPD = chronic obstructive pulmonary disease; EOC = episode of care; FFS = fee for service; health IT = health information technology; MCP = managed care plan; OH CPC = Ohio Comprehensive Primary Care; TA = technical assistance.

Ohio created referral reports, which included claims-based quality and cost data for PAPs. Initial reports made available in 2017 included provider data for asthma, COPD, and perinatal episodes; additional episodes will be added over time. Ohio distributed the referral reports to both OH CPC practices and PAPs, although the reports were primarily targeted toward OH CPC practices. The referral reports distributed to OH CPC practices included the cost and quality scores of PAPs within an area to which the OH CPC practices could refer and indicated which patients attributed to the OH CPC practices were involved in the episodes. The referral reports provided to PAPs enabled them to compare their quality and cost outcomes with those of other PAPs.

Medicaid provider and plan stakeholders generally reported that referral reports were not yet receiving attention, although some more sophisticated practices reportedly had used them. Asked about providers’ use of data to make improvements, one state official noted that most providers were still trying to interpret data included in the referral reports, and as a result, had not yet changed referral or practice patterns in response to the reports.

Practice transformation and workforce development infrastructure

To support practice engagement with EOC and OH CPC initiatives, Ohio continued to host periodic Webinars to inform providers about the initiatives. Additionally, for the first time, the state convened 2 days of in-person learning meetings for CPC providers, with presentations by CPC practices on innovative approaches to providing care and opportunities to provide program feedback. In addition, Ohio concluded its first round of practice monitoring and initiated TA for targeted OH CPC practices needing improvement.

One provider representative provided positive feedback on the in-person learning sessions and expressed disappointment there had not been more such meetings. The provider stated the sessions were well attended and participants were engaged in the discussions. The same provider also observed that session participants were pleased with the outcomes of the sessions and were interested in participating in future in-person meeting.

In July 2017, the state launched practice monitoring and in spring 2018, offered TA to targeted OH CPC practices needing improvement. Practice monitoring was conducted to ensure that OH CPC practices met the eight activity requirements practices must carry out for OH CPC participation. Activity requirements included offering same-day appointments, following up with patients after discharge from the hospital, and providing team-based care. The practice monitoring process included phone interviews with all practices and site visits to a subset of practices. Based on the results of the practice monitoring process, Ohio required certain OH CPC practices to undergo TA to meet all components of the activity requirements.

H.2.4 Population health

Key Results
<ul style="list-style-type: none">• The state developed a dental episode addressing opioids, adding another link to the population health priority of mental health and addiction.• The state launched its online repository of local needs assessments and community benefit hospital spending plans.

Ohio continued the population health work of (1) aligning its EOC metrics with the priority areas previously identified through the State Health Assessment and State Health Improvement Plan and (2) coordinating state and local health care and public health needs assessments and reports. To address the priority areas of addiction and mental health, Ohio developed a dental episode to address opioid addiction. To support local needs assessment activities and related state legislative mandates, Ohio launched the planned online repository of local health and community benefit hospital needs assessments and community benefit hospital spending plans, as well as an online database of population health indicators (*Table H-5*).

“I get the relationship to SIM...I don’t know if everybody does. Mostly because a lot of the folks in the [State Health Improvement Plan] SHIP space were not involved with episodes or PCMH development. They are public health departments. They are not primary care or hospitals. But the fact that they are both happening and running at the same time gets us very quickly to that whole health of a person and population health.”

—Consumer organization representative

Table H-5. Ohio’s progress on population health

Activity	Target population	Key activities	Progress between May 1, 2017, and March 31, 2018
State Health Assessment and State Health Improvement Plan	<ul style="list-style-type: none"> Entire population of Ohio Medicaid members with providers participating in EOCs or OH CPC Local public health departments and community benefit hospitals 	<ul style="list-style-type: none"> Identification of statewide priorities Alignment of EOC and OH CPC measures with population health priorities Alignment of needs assessment cycles and public posting of reports 	<ul style="list-style-type: none"> Developed an additional episode on dental care to address the mental health and addiction priority. Launched the online repository for the needs assessments and hospital expense reports.

EOC = episode of care; OH CPC = Ohio Comprehensive Primary Care.

Some providers and payers raised the social determinants of health. One state official believed the move to VBP had increased interest the issue of social determinants of health.

H.2.5 Governance and sustainability

Key Results

- Stakeholders were concerned that the upcoming change in Governor could have a negative impact on sustaining SIM strategies.
- State officials were working to promote SIM strategy sustainability by packaging information and budgets for the next administration, increasing staff, and transferring knowledge to state staff and contractors to maintain OH CPC and EOCs.

Stakeholders described the upcoming change in Ohio governance as potentially having an impact on the sustainability of strategies implemented under the leadership of the current term-limited Governor and his OHT. Some stakeholders saw the current Governor’s commitment to health care transformation and the leadership of OHT, created by executive order, as being essential ingredients to the success of the SIM Initiative. Regardless of the outcome of the election in November 2018, the change in Governor and the end of the OHT led many to express concern about the future of SIM strategies in the state.

The SIM state leadership team, which might not be in place by the beginning of 2019, began work in the AR3 analysis period on their priorities to foster sustainability of the SIM work. These priorities are financing and agency capacity to carry on SIM work. The state brought on an additional staff person to focus on SIM sustainability during the AR3 analysis period.

State officials worked to “package” the SIM work for the next administration and to prepare a budget for the next Governor that “baked in” the funds for PMPM payments. OH CPC shared savings were to come from reduced spending; EOC incentives were designed to be cost neutral. Although stakeholder views on the adequacy of the PMPM payments varied, state officials and most stakeholders saw them as crucial to sustaining OH CPC. State officials planned to address how to translate the SIM Initiative into “practical results” that could be used to convince the state legislature of SIM’s importance—a task several external stakeholders also saw as vital.

Officials also focused on internal agency readiness. This work included completing the transfer of functions from consultants—brought on to assist with SIM implementation—to state contractors with ongoing responsibilities. The state also planned to bring on additional staff and to integrate SIM-related work into current staff’s job responsibilities.

State officials had not engaged in much discussion about sustainability with external stakeholders. The most influential stakeholders were key hospitals, in one official’s view, which he believed were behind the SIM Initiative and would support it. Other interviewees expressed an interest in supporting the state efforts to sustain SIM strategies, although most of this interest was described as contingent on knowing more about SIM’s implementation and results. MCP representatives also set the issue of sustainability in a larger context. In addition to uncertainties due to the change in Governor, MCPs also were concerned about how SIM activities might fit into future directions at the federal level.

“The PCMH/CPC is very palatable to providers. It’s relatively straightforward in terms of application and adoption of the model. The payment models are very consistent these days across MCOs [managed care organizations], commercial payers, and CMS, so there is broad support for adoption.”

—Commercial plan representative

Several stakeholders saw OH CPC as more likely to be sustained than EOCs. These stakeholders saw EOCs, while valuable, as more complex to explain, advocate for, and sustain than OH CPC.

Health plans also suggested the state accelerate its move toward VBP and away from FFS to make more substantial progress toward transformation. An MCP representative suggested case rates for EOCs, rather than retrospective payments. Another recommended downside risk for OH CPC. There was general agreement that data exchange and provider support were crucial to the state’s ability to make such changes.

Stakeholders, especially those with nonprofit organizations outside the health care delivery system, also had ideas on how the state should focus its efforts to promote SIM sustainability going forward. In addition to informing and educating the state legislature, suggestions included evaluation to determine and sell any positive SIM results, communication with the broader set of stakeholders who were engaged in the initial design phases of SIM, and dissemination of SIM-based learning throughout the Ohio health care system.

H.3 Implications of Findings/Lessons Learned

The Ohio SIM Initiative achieved significant changes during the AR3 analysis period:

- Launched reporting for new episodes, bringing the total to 43.
- Disbursed positive and negative financial incentives for three EOCs and tied six additional episodes to payment.
- Increased the number of practices participating in OH CPC by 50, despite a budget cut.
- Introduced referral reports to inform OH CPC practices about the quality and cost of care PAs provided.

- Contracted with a firm to monitor OH CPC practice compliance, which identified practices needing TA.

Based on the SIM implementation experience, stakeholders offered several opportunities, remaining challenges, and lessons learned for other states:

- The OH EOC program faced challenges in engaging providers, plausibly because of the retrospective incentives, insufficient payment incentives, and limited utility of reports.
- PMPMs were an important element to sustaining the OH CPC initiative.
- Alignment with federal initiatives, such as CPC+, created further momentum for transformation.
- Engaging health plans in the move to VBP had the side benefit of increasing communication and coordination between plans and providers, and among the plans themselves.
- Educating state legislators about VBP and related state strategies was important to sustaining those strategies.

Appendix I. State Innovation Model in Model Test States: Rhode Island

Key Results from Rhode Island's State Innovation Model Initiative May 2017–March 2018

Strategies, progress, and accomplishments, May 2017–March 2018

- Rhode Island continued practice transformation assistance to patient-centered medical home (PCMH)-Kids and adult PCMHs participating in the state's integrated behavioral health (IBH) pilot.
- PCMHs participating in the IBH pilot increased the number of adults receiving screening for depression, and some PCMHs began to show lower per member per month (PMPM) costs than PCMHs not participating in the pilot.
- By April 2018, stakeholders estimated that 70 percent of primary care physicians would be affiliated with a PCMH.
- All-payer claims database (APCD) analytics began to show quantitative results for the PCMH program.
- Completed the implementation of the care management dashboard in all eight community mental health centers (CMHCs).
- As of March 2018, the Screening, Brief Intervention, and Referral to Treatment (SBIRT) Training and Resource Center had trained more than 700 providers in how to identify substance use disorders in adults.
- Three integration and alignment projects directed at population health were implemented.

Stakeholder response to implemented strategies

- Both providers and payers identified the creation of an aligned measure set for providers and payers as one of the SIM Initiative's chief accomplishments.
- Most stakeholders believed the CMHC dashboards were already having a positive impact on reducing utilization for patients with complex behavioral health conditions.
- Stakeholders were optimistic about reaching the state's goal of 80 percent of health plans adopting alternative payment models (APMs) by the end of 2018, based partly on the Office of the Health Insurance Commissioner's (OHIC's) strong regulatory powers.

Remaining challenges

- Payers' reimbursement policies had not yet adapted to delivering behavioral health services in a primary care setting, posing challenges for providers working in an integrated practice.
- Lack of a clear use case and data quality challenges led the state to reassess the feasibility of developing a statewide provider directory.
- Demonstrating longer-term outcomes, particularly those related to population health, is challenging, due to the short time period of the SIM award.

Sustainability after the SIM award

- The Steering Committee began planning for the ongoing support of successful SIM projects through establishment of a sustainability work group.
- Two SIM projects, APCD and CMHC dashboards were already self-sustaining.
- The state's investment in creating a culture of collaboration focused on alignment among agency initiatives promoted sustainability by integrating activities into ongoing operations and public-private partnerships.

Rhode Island’s SIM Initiative began on February 1, 2015. SIM leaders’ vision for the SIM award is to help providers deliver more value-based care by investing in the expansion of the state’s PCMH program and advancing the integration of physical and behavioral health care across the state. Central to this vision is aligning approaches to expanding APM adoption among commercial and Medicaid payers and expanding provider and payer access to health care data.

“Rhode Island’s payment system is changing to focus more on value and less on volume. IF Rhode Island SIM makes investments to support providers and empower patients to adapt to these changes, and we address the social and environmental determinants of health, THEN we will improve our population health and move toward our vision of the ‘Triple Aim’ [Healthier People, Better Care, Smarter Spending].”

—RI SIM Theory of Change, Operational Plan, May 2017.

This updated overview of the Rhode Island SIM Initiative is based on analysis of data collected from site visits, stakeholder telephone interviews, state document reviews, and state program and evaluation calls between May 1, 2017, and March 31, 2018, the Annual Report (AR) 3 analysis period. Further details on the analytic approach are available in **Chapter 1**. Information on the number and types of stakeholders interviewed for the state is in **Table 1-1**. **Figure 1-1** depicts the timeline of major Rhode Island SIM Initiative and SIM-related activities to date.

I.1 Key State Context and Progress Prior to May 2017

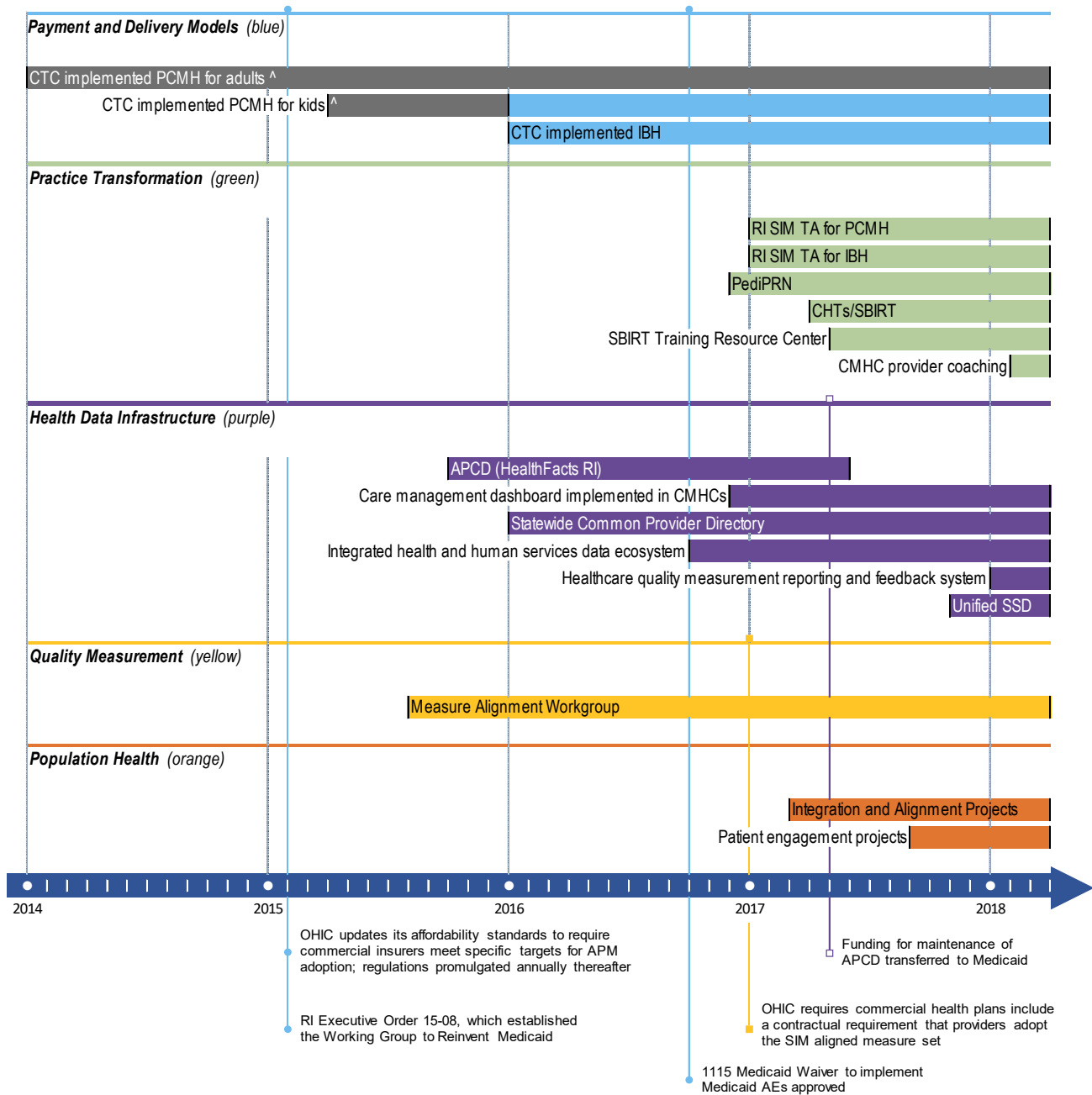
I.1.1 Pre-State Innovation Model health care in Rhode Island

Rhode Island is a geographically small state with a population of 1.06 million,¹ 95 percent of whom have health insurance coverage. The state is largely urban, with less than 10 percent of its population in rural areas. The commercial health insurance market is highly concentrated, with only four major carriers (Blue Cross & Blue Shield of Rhode Island, Neighborhood Health Plan of Rhode Island, UnitedHealthcare, and Tufts Health Plan).

Rhode Island has a long history of supporting provider and payer transition to value-based care delivery. Since 2008, the state has fostered the adoption of PCMHs and used its regulatory and contractual authority to advance APM adoption among private and public payers. Rhode Island is unique in being the only state with a state agency charged solely with regulating commercial health insurers, OHIC. Since 2004, OHIC has played a key role in moving commercial insurers away from fee for service (FFS) toward greater adoption of value-based payment (VBP) strategies. On an annual basis, the agency creates a set of APM targets and structures to support advanced primary care, within the annual review of their Affordability Standards, that commercial health plans are required to adhere to in their provider contracts.

¹ United States Census Bureau. (n.d.). *QuickFacts: Rhode Island*. Retrieved from <https://www.census.gov/quickfacts/RI>

Figure I-1. Timeline of Rhode Island State Innovation Model and State Innovation Model-related activities



AE = Accountable Entity; APCD = all-payer claims database; APM = alternative payment model; CHT = community health team; CMHC = community mental health center; CTC = Care Transformation Collaborative; IBH = integrated behavioral health; OHIC = Office of the Health Insurance Commissioner; PCMH = patient-centered medical home; PediPRN = Pediatric Psychiatry Resource Network; RI = Rhode Island; SBIRT = Screening, Brief Intervention, and Referral to Treatment; SIM = State Innovation Model; SSD = Social Services Directory; TA = technical assistance.

Note: Gray bars (with [^]) denote that the items are not SIM activities or policies but are important for context.

I.1.2 State Innovation Model initiative progress and changes prior to the Annual Report 3 analysis period

To ensure the success of its SIM Initiative, Rhode Island deliberately integrated and aligned each of its SIM-funded investments with existing health care delivery reform initiatives happening in the state. A multi-stakeholder/multi-agency Steering Committee establishes SIM priorities and makes SIM funding decisions, thereby helping to create a “culture of collaboration” in the state. The SIM staffing structure was designed to promote state agency collaboration, with SIM award funds supporting staff in five state agencies.

The foundation for many of the SIM Initiative’s investments is the state’s long-standing PCMH program, which began with five pilot sites in 2008. Over the past decade, Rhode Island’s multi-payer PCMH initiative, Care Transformation Collaborative of Rhode Island (CTC-RI), has grown to 81 primary care practice sites, including internal medicine, family medicine, and pediatrics, through PCMH-Kids. The SIM Initiative has invested heavily in practice transformation assistance to expand PCMHs to the pediatric population (under PCMH-Kids) and increase access to behavioral health services in primary care settings. The state also has directed substantial resources toward upgrading the state’s APCD, financing implementation of a care management dashboard, and creating a health care quality, reporting, and measurement system to facilitate providers’ use of data for quality improvement.

Since SIM implementation, Rhode Island has engaged in several federal initiatives that complement the state’s efforts in APM adoption and improve access to health care for Rhode Island citizens. Current initiatives funded by CMS include Comprehensive Primary Care Plus (CPC+), which is an advanced PCMH model that offers an innovative payment structure to support delivery of comprehensive primary care, and the Transforming Clinical Practice Initiative (TCPI), which helps clinicians achieve practice transformation through adapting and further developing their comprehensive quality improvement strategies. Other federal initiatives include an Accountable Health Communities award; Executive Office of Health and Human Services’ (EOHHS’) Integrated Care Initiative, which was designed to better align Medicare and Medicaid; Rhode Island Department of Health’s (RIDOH’s) work on the Centers for Disease Control and Prevention’s 6|18 Initiative;² and an amendment to the state’s 1115 Waiver to implement the Rhode Island Health System Transformation Project to support an incentive program for hospitals and nursing homes, a health workforce development program, and the previously described Medicaid Accountable Entities (AEs).

The state’s EOHHS took a more aggressive stance in encouraging APM adoption in its Medicaid program in 2016, when the state initiated the Medicaid AE Pilot. This pilot enabled

² CDC. (2018). *CDC’s 6|18 Initiative: Accelerating evidence into action*. Retrieved from <https://www.cdc.gov/sixteen/index.html>

qualified provider organizations to contract with Medicaid managed care organizations on a total-cost-of-care basis. Participating AEs also can earn infrastructure funding to improve care integration and population health. As of July 2017, about 90 percent of all Medicaid beneficiaries in Rhode Island were enrolled in a Medicaid managed care organization.

I.2 Progress and Accomplishments from Rhode Island’s State Innovation Model Initiative, May 2017–March 2018

I.2.1 Delivery models and payment reforms

Key Results
<ul style="list-style-type: none">• Seven of nine PCMH-Kids practices demonstrated improved screening rates for maternal depression, after participating in a SIM-funded Maternal Depression Learning Collaborative.• PCMH practices participating in the IBH pilot reported increased capacity to treat patients with behavioral health conditions.• PMPM costs for five participating IBH practices were, on average, \$100 lower than those of a statewide PCMH comparison group.• Payers’ reimbursement policies and procedures had not yet adapted to health care delivery changes in practices providing integrated primary and behavioral health care.

During the AR3 analysis period, the SIM Initiative continued delivering practice transformation support to 9 PCMH-Kids practices and 10 adult PCMHs participating in a pilot program to integrate behavioral health services into their practices (*Table I-1*). SIM support for these two investments, begun in January 2017, is expected to continue through fall 2018.

PCMH-Kids

During the AR3 analysis period, PCMH-Kids practices continued to receive on-site technical assistance (TA) from a coach who helped practices administer the Consumer Assessment of Healthcare Providers and Systems pediatric survey, collect data for quality measurement, and implement performance improvement projects. A provider coach also worked with these practices to enhance their capacity to treat parents and children with behavioral health issues. Although not funded directly with SIM dollars, many practices hired behavioral health care managers to help with complex patients. Seven of the nine practices also implemented screening for maternal depression. SIM leaders credited this assistance with helping primary care practices, not only increasing the overall quality of care provided to children and their families, but also strengthening physician relationships with behavioral health providers.

Table I-1. Rhode Island’s progress on delivery system and payment reforms

Activity	Target population	Key activities	Progress between May 1, 2017, and March 31, 2018
PCMH-Kids	30,000 children served by 9 primary care practices	Practice facilitation coach helping practices, implementing screening tools, interpreting quality metrics, and design quality improvement projects to address problem areas	<ul style="list-style-type: none"> All 9 PCMH-Kids practices met clinical quality metrics related to BMI and developmental screening.¹ Seven of the 9 participating practices demonstrated improved screening rates for maternal depression, after participating in the Maternal Depression Learning Collaborative. The kickoff meeting for the Behavioral Health Learning Collaborative focused on SBIRT was held in March 2018.
IBH Pilot	Approximately 50,000 adults served by 10 PCMHs	Practice facilitation coach to help practices implement screening, integrate a BH clinician into care teams, and report on cost and utilization metrics	<ul style="list-style-type: none"> All practices increased the number of adults receiving screening for anxiety, depression, and substance use. Practices embedded a BH clinician into their care teams. Analyses using most recent available APCD data demonstrated that the PMPM costs for 5 participating IBH practices, on average, were \$100 lower than those of a statewide PCMH comparison group.²

APCD = all-payer claims database; BH = behavioral health; BMI = body mass index; IBH = integrated behavioral health; PCMH = patient-centered medical home; PMPM = per member per month; SBIRT = Screening, Brief Intervention, and Referral to Treatment.

¹ Presentation on PCMH-Kids Accomplishments for 2018 presented on 6/7/18. Accessed at <https://www.ctc-ri.org/sites/default/files/uploads/PCMH%20Kids%20June%20Stakeholder%20Accomplishments%20PPT.pdf>

² Care Transformation Collaborative Presentation: What’s Integrated Care Got to Do With It? May 11, 2018.

An ongoing challenge to PCMH-Kids implementation is creating a model that addresses the unique needs of children. One state official described it as important to ensure that (1) the practice transformation support delivered to PCMH-Kids practices met the unique needs of the pediatric provider community, as opposed to just replicating what PCMHs that serve adults receive; and (2) the recognition standards and performance metrics adopted for PCMH-Kids reflected meaningful differences among the two populations.

“While a [nonclinical] care manager may be effective in an adult PCMH practice, a nurse practitioner may be more appropriate in a pediatric office.”
 —State official

Provider stakeholders described their administrative burden as a major obstacle to PCMH-Kids implementation. In Rhode Island, primary care practices must demonstrate effective implementation of 80 percent of a set of requirements to be recognized by the state as a PCMH. These requirements include establishment of a high-risk patient registry, care management activities

directed at reducing emergency room use or utilization more generally, policies to improve access to behavioral health services, expanded office hours, and referral protocols informed by cost and quality data.³ Primary care practices must also meet National Committee for Quality Assurance (NCQA) standards and the state requirements to become certified PCMHs. In response to provider complaints that the requirements were duplicative, the state agreed to better align its PCMH requirements with NCQA recognition standards and reduce the number of processes practices are expected to implement for state recognition.

Integrated behavioral health

The SIM Initiative continued its support for a demonstration program with 10 PCMHs to integrate behavioral health staff and services into practice workflow. The IBH pilot, which is scheduled to end in October 2018, has three components: (1) implementing universal screening for depression, anxiety, and substance use disorder; (2) embedding a behavioral health clinician (social worker or clinical psychologist) in the practice to provide treatment and referrals, as needed; and (3) on-site coaching from a licensed clinical psychologist to teach practices how to integrate behavioral health practitioners into care teams and address other integration issues as they arise.

Both provider participants and state officials universally praised the IBH pilot for its success in expanding practices' capacity to treat patients with behavioral health disorders.

Practices reported appreciable increases in screening rates for depression, anxiety, and substance use disorder (with 80 to 90 percent of all patients screened). Provider participants also indicated a notable impact from having an on-site behavioral health professional available to respond immediately to patients with mental health or substance abuse concerns. Patients were described as being more inclined to schedule a follow-up appointment and receive timely treatment for a mental

health concern, when they experienced a warm hand off to a behavioral health practitioner during a regular office visit.

"For me, not coming from an integrated model, it forced me to learn a lot more about the medical comorbidities and understand the illnesses better. When I first started, a doc would come by for a warm hand-off if somebody was crying in their office, but there wasn't a lot of assessment So many things have changed, and I've had to learn a lot about understanding medical illnesses so that I can better treat folks."

—Behavioral practitioner working within an IBH setting

Providers also credited participation in the IBH pilot with helping to “change the culture of practice” within a primary care setting. With assistance from the practice coach, primary care practitioners and behavioral health professionals learned how to collaborate and work better together as team members. Both practitioner types reported feeling more comfortable in addressing health issues outside their normal standard of practice.

³ The 2018 Care Transformation Plan can be accessed at <http://www.ohic.ri.gov/documents/2018-Care-Transformation-Plan-Final-Adopted-01-24-2018.pdf>.

Providers identified challenges to implementation identified that pertained largely to reimbursement. Billing and coding policies for services delivered in an integrated health care practice were described as particularly confusing and frustrating. Some services were not reimbursed under current commercial payment rules (e.g., depression screening administered by a primary care physician and insurers required different billing codes for the same service). Additionally, patients were subject to dual copayments during an office visit when they saw a primary care practitioner and a behavioral health specialist on the same day. In response to these ongoing concerns from practitioners, the SIM Initiative funded a consultant to research these barriers and convene a work group to facilitate dialog between payers and providers to address such problems.⁴ Results from this analysis were to be used to inform TA activities to practices in Award Year (AY) 4.

Members of the SIM Steering Committee and stakeholder groups successfully advocated to prevent a proposed reduction in Medicaid funding for PCMH-Kids. During fall 2017, the state proposed a \$400,000 reduction in Medicaid funding for PCMH-Kids, due to budget shortfalls. In response, stakeholders effectively demonstrated the important role PCMH-Kids plays in advancing the state’s overall health care transformation objectives of encouraging sustained investments in primary care. However, a few stakeholders did express concern about the sustainability of the PCMH initiative moving forward, because it had not shown a clear return on investment. According to one provider, the benefits from the investments might not accrue for 20 to 30 years. Further, because treating children was less expensive than treating adults, demonstrating savings from the PCMH-Kids program could be commensurately more challenging. A few respondents were more optimistic about the future of the IBH initiative, as recent analyses were beginning to show savings for patients with behavioral health conditions treated within an IBH practice.

1.2.2 Progress toward a preponderance of care in value-based payment and alternative payment models

Key Results
<ul style="list-style-type: none"> • Commercial insurers in Rhode Island reported that 46 percent of payments were made through an APM and that 56 percent of primary care physicians participated in PCMHs. • Stakeholders reported that the state was close to designating 70 percent of primary care practices as PCMHs by the end of April 2018. • Stakeholders were optimistic about reaching the state’s goal of 80 percent of health plans adopting APMs by the end of 2018, based partly on OHIC’s strong regulatory powers.

⁴ OHIC 2018 RI SIM Updated Operational Plan—April 2018.

As of December 2017, commercial insurers in Rhode Island reported that 46 percent of insured medical payments were made through an APM, and 56 percent of primary care physicians were participating in PCMHs.⁵

Some interviewees believed the state was close to designating 70 percent of primary care practices as PCMHs by the end of April 2018.

Rhode Island continues to require health plans to adhere to the state's affordability standards promulgated by OHIC and published in January of each year.⁶ The targets for APM adoption presented in the 2018 APM plan for 2018 and 2019 are the same as those approved in 2017 because, according to state regulators, commercial insurers requested additional time to comply with the metrics. By the end of 2018, health plans were required to have 50 percent of insured medical payments made through an APM. The target for commercial insurers remains the same for 2019.

As of December 2017, 56 percent of primary care physicians participated in PCMHs.

Stakeholder reports indicated that the state was close to designating 70 percent of primary care practices as PCMHs by the end of April 2018. Health plans were required to have 80 percent of their contracted primary care providers (PCPs) participating in a PCMH by the end of 2019 (70 percent by the end of 2018). The 2018 regulations also included two additional metrics insurers had to meet by the end of 2018: (1) a non-FFS target, which required that insurers move 6 percent of insured medical payments into non-FFS APMs; and (2) a risk-based contract target, which mandates that insurers have 10 percent of insured covered lives enrolled in risk-based contracts.⁷

Stakeholders generally regarded the federal preponderance of care targets as attainable for Rhode Island because of OHIC's role. Optimism about meeting these targets was largely attributed to the existence of OHIC, which, as a regulator, clearly served as a powerful transformation lever. Other factors stakeholders mentioned as contributing to their optimism were the existence of the CTC, which has made notable inroads in expanding PCMHs throughout the state, and Medicaid's recent launch of its AE pilot, which, as of September 2017, covered just over 50 percent of the state's Medicaid managed care population.⁸

⁵ OHIC Presentation to the SIM Steering Committee on March 8, 2018. Marie Ganim, Health Insurance Commissioner. Accessible in Steering Committee Meeting Minutes:

<https://sos.ri.gov/documents/publicinfo/omdocs/minutes/6436/2018/60284.pdf>

⁶ OHIC. (2018, January 24). *Rhode Island 2018 Alternative Payment Methodology Plan Adopted by Health Insurance Commissioner Marie Ganim*. Retrieved from <http://www.ohic.ri.gov/documents/2018-Alternative-Payment-Methodology-Plan-FINAL-2018-1-24-FINAL.pdf>

⁷ 2018 Care Transformation Plan and APM Plan.

⁸ Accountable Entity Presentation, March 2018.

One of OHIC’s primary strategies for reaching 80 percent provider participation in PCMHs by December 2019 is to target primary care physicians practicing within an AE or commercial accountable care organization (ACO).

Because recognition requirements and transformation activities for ACOs and PCMHs are similar, the agency expected these practices to meet the state PCMH certification requirements relatively easily. Several stakeholders noted that any remaining resistance to PCMH adoption was likely to come from older, independent physicians nearing retirement. In spring 2017, OHIC convened a work group to identify the barriers to transformation for small practices, which concluded that many older physicians did not have electronic health records (EHRs) and were less motivated than their younger counterparts to make the necessary changes required to transform.

“These (PCMHs) are not risk-contracts ... I’m not sure what we are doing in PCMH really qualifies as VBP when you are just layering an incentive or bonus payment on top of FFS.”

—State official

A few stakeholders mentioned that most APM penetration in Rhode Island consisted largely of upside risk-only contracts. Population-based or capitation models, which include downside risk for providers, constituted a very small percentage of APMs in the state. Some stakeholders questioned whether the PCMH payment model in its current form truly constituted the type of VBP intended to effectively shift payment the system from FFS.

All stakeholder types agreed that they would like to see more specialists included in VBP discussions. According to one payer, to achieve real savings, both primary care physicians and specialists need to be involved in conversations about transforming the health care system to achieve real savings, but only primary care physicians had been involved in payment reform meetings so far. OHIC established risk-based contract targets for commercial insurers to meet for calendar years 2018 and 2019 (10 percent in 2018, and 30 percent in 2019), but some interviewees noted that meeting these targets could be particularly challenging. Most providers are apprehensive about accepting risk, according to many stakeholders, particularly when required to participate in multiple contracts across payers, all of which require their own savings thresholds and risk requirements.

OHIC acknowledges that the uptake of non-FFS-based payment models in Rhode Island has been slower than anticipated. To address this issue, the agency is currently facilitating a work group process between PCPs and payers to design a primary care APM pilot. Additionally, the agency was recently awarded a grant from the Robert Wood Johnson Foundation to analyze variations in health care spending across the state to inform the development of episodes of care (EOCs).

Table I-2 presents the extent to which Rhode Island’s population participated in the SIM payment and health care delivery models. These values were provided by the state in its AY3, Report 3 progress report to CMMI. The state has presented more recent data, described below.⁹ For the state’s commercial populations, Rhode Island provided a unique count of 243,385 insured individuals attributed to either a PCMH or ACO, representing 67.2 percent of the state-reported number of commercial health plan members. Rhode Island reported that 35,991 children were attributed to a pediatric PCMH as a part of the PCMH-Kids program; however, the percentage of the commercial pediatric population attributed to a PCMH was not reported.

Table I-2. Populations reached by a value-based payment or alternative payment model in Rhode Island, latest reported figures as of Award Year 2, Annual Report

Payer type	SIM models			Landscape
	Integrated Behavioral Health	Other ¹	SIM Initiative-wide	Any VBP or APMs
Commercial	—	35,991 (—)	—	243,385 (67.2%)

Source: Rhode Island SIM Quarterly Progress Report for Award Year 3, Report 3.

— = relevant data not provided in the data source; APM = alternative payment model; PCMH = patient-centered medical home; SIM = State Innovation Model; VBP = value-based payment.

¹ “Other” refers to pediatric PCMH (PCMH-Kids).

Note: The landscape total includes the unique members attributed to a PCMH or ACO. The denominator is the number of insured members. Rhode Island’s preponderance of care strategy includes adult PCMH models that existed in Rhode Island prior to SIM implementation. SIM funding supports a variety of activities for these practices.

Reporting accurate preponderance of care penetration rates was, and might continue to be, a challenge for the state. Although commercial data were reported, Medicaid data were not yet available. Although Medicaid managed care plans in Rhode Island were required to meet the same annual targets for APM adoption as commercial plans, OHIC and Medicaid collected and measured different payment metrics. At the end of the AR3 analysis period, OHIC and Medicaid were planning on creating a unified reporting template to better align APM metrics across the two agencies. The Rhode Island SIM team expects Medicaid APM data to be available in time for the next annual report. Although IBH payment models were implemented by Rhode Island SIM, data for the populations covered by these models were not available for second quarter AY3.

⁹ These data values were not verified by CMMI. Thus, the RTI team cannot attest to their accuracy.

Table I-3 presents the extent to which Rhode Island’s payers participated in VBP or APM, as defined by the Learning and Action Network categories in AY2. Because Rhode Island reports these metrics on an annual basis, AY3 metrics are not yet available. As previously described, Medicaid data were not yet available. Compared to the baseline metrics previously reported by the state, the percentage of payments made by commercial payers for fee-for-service (FFS) with no link to quality (Category 1) and payments linked to quality (Category 2) remained fairly constant over time. However, payments made under APMs (Category 3) increased from 24 percent of payments to providers in AY1 to 44 percent in AY2. Commercial payers in the state supported no global risk contracts in AY1 or AY2.

Table I-3. Payers participating in a value-based payment or alternative payment model in Rhode Island, latest reported figures as of Award Year 2

Payer	Category 1 Payment: FFS with no link of payment to quality		Category 2 Payment: Payment linked to quality		Category 3 Payment: APMs		Category 4 Payment: Population-based payment	
	Number of beneficiaries	Percentage of payments	Number of beneficiaries	Percentage of payments	Number of beneficiaries	Percentage of payments	Number of beneficiaries	Percentage of payments
	Commercial	—	37%	—	63%	—	44%	0
Medicaid	—	—	—	—	—	—	—	—
Medicare	—	—	—	—	—	—	—	—

Source: Rhode Island SIM Quarterly Progress Report for Award Year 3, Report 3.

— = relevant data not provided in the data source; APM = alternative payment model; FFS = fee for service.

¹ There are currently no global risk contracts in the Rhode Island market.

Note: Totaled payments equal more than 100% because Rhode Island data collection practices define Category 3 payments as a subset of Category 2 payments.

Table I-4 presents the number of Rhode Island providers participating in the payment and health care delivery models. Because Rhode Island reports PCMH and ACO metrics on an annual basis, AY3 metrics were not yet available. IBH practice participation data is reported quarterly and therefore reflects the second report of AY3. Data for AY2 showed substantial participation of PCPs attributed to a PCMH or ACO, with 85 percent of PCPs and over 75 percent of practices attributed to one or the other. Compared to baseline data, Rhode Island demonstrated an increase in provider participation in all categories. Ten practices were participating in IBH at the end of AY2 (83 percent of the initial 12 practices that were invited to participate). There were none reported for AY1. Nine practices are participating in PCMH-Kids. And a substantial percentage of the providers (90.7 percent) within those practices were engaged in the model as of AY2 (there were no pediatric providers engaged in PCMH-Kids in AY1).

Table I-4. Providers participating in a value-based payment or alternative payment model in Rhode Island, latest reported figures as of Award Year 2, Annual Report

Provider type	SIM models			Landscape
	Integrated Behavioral Health	Other ¹	SIM Initiative-wide	Any VBP or APMs
PCP	—	68 ² (90.7%)	—	1,002 ³ (85.0%)
Provider organizations	10 ⁴ (83.3%)	9 (—)	—	424 ⁵ (75.2%)

Source: Rhode Island SIM Quarterly Progress Report for Award Year 3, Report 3.

— = relevant data not provided in the data source; APM = alternative payment model; PCMH = patient-centered medical home; PCP = primary care provider; SIM = State Innovation Model; VBP = value-based payment.

¹ “Other” refers to pediatric PCMH (PCMH-Kids).

² The denominator is the total number of clinicians in participating pediatric PCMH (PCMH-Kids) practices.

³ The statewide total is the unique count of providers participating in a PCMH or ACO. The denominator is the total number of providers in the state.

⁴ This metric is submitted quarterly and therefore reflects the most recent data submitted for AY3, Report 2. The denominator is the total number of practices invited to participate in the initiative.

⁵ The statewide total is the number of unique provider organizations transformed into PCMHs or organized into ACOs. The denominator is the total number of provider organizations in the state.

1.2.3 Enabling strategies to support health care delivery transformation

Key Results

- Stakeholders continued to view quality measure alignment as a major SIM success—reducing administrative burden for payers and providers and leading to adoption of the aligned core measure set and quality framework.
- Stakeholders viewed the CMHC care management dashboards as very effective in coordinating care and reducing inpatient hospital admissions for behavioral health consumers.
- The SBIRT Training and Resource Center trained more than 700 providers in identifying substance use disorders, providing brief interventions, and referring to treatment.
- As of March 2018, the Pediatric Psychiatry Resource Network (PediPRN) program had provided more than 400 telephonic psychiatric consults to PCPs and pediatricians and related health care professionals.

As of March 2018, payers and providers used the aligned measure set, all but one of the practice transformation and workforce initiatives were in operation, and all four patient engagement projects were launched (*Table I-5*). Although all health information technology (health IT) projects had been implemented, some projects were proceeding slower than initially planned. The state’s experiences with less than expected stakeholder buy-in, combined with technological difficulties in one of the earlier health IT projects, caused the state to proceed more cautiously with subsequent projects.

Table I-5. Rhode Island’s progress on enabling strategies to support health care delivery transformation

Activity	Target population	Key activities	Progress between May 1, 2017, and March 31, 2018
Quality measure alignment	Commercial payers and providers	Aligning quality measures across payers to reduce provider burden and generate buy-in to VBP	<ul style="list-style-type: none"> Conducted annual measure updates and refinement. Updated regulations on the use of aligned measure sets and applicable contracts for use of the aligned measure set published November 2017. Medicaid instituted requirements mandating Accountable Entities report on measures included in the SIM core measure sets.
Health IT projects	Broad range of policy makers, including health and human service agencies, payers, and providers, including CMHCs	Conducting 6 projects to (1) increase the state’s analytic capability to improve quality of care and guide policy development and (2) support providers in engaging in practice transformation through providing tools for coordinating patient care	<ul style="list-style-type: none"> The APCD provided data to calculate quarterly metrics for PCMH and IBH pilots. Procurement for eCQM reporting was finalized in January 2018. In December 2017, the integrated health and human services data ecosystem governing board was developed with broad agency representation; a Data Use Agreement was signed by all agencies in early 2018. Care Management Dashboard became operational in 7 CMHCs, with providers reporting successful impact on care coordination. Each CMHC negotiated customized alert systems to meet the CMHC’s specific needs. Sought TA and reevaluated use case for the Common Provider Directory, a Web-based database designed to house detailed provider information. Identified vendors for the Unified SSD.
Practice transformation and workforce projects	Providers throughout the state, especially pediatric PCPs, BH providers, and CHTs	Conducting 4 projects to help providers thrive under VBP and enhance their ability to provide BH care	<ul style="list-style-type: none"> The CHT/SBIRT project benefited 8 CHTs, including 3 partially created with SIM funding, and integrated SBIRT screening within CHTs and partner sites. The SBIRT Training Center trained >700 providers. PediPRN provided >400 consultations to pediatric PCPs since December 2016. Awarded contract to provide BH provider coaching in March 2018.
Statewide workforce planning	Broad range of policy makers, payers, and providers	Planning and implementing strategies to improve and expand the health system workforce	<ul style="list-style-type: none"> Issued the <i>Healthcare Workforce Transformation Report</i> in May 2017. Convened a summit in June 2017.

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(continued)

Table I-5. Rhode Island’s progress on enabling strategies to support health care delivery transformation (continued)

Activity	Target population	Key activities	Progress between May 1, 2017 and March 31, 2018
Patient engagement projects	Patients facing end-of-life decisions or children with social-emotional challenges, depending on project	Conducting 4 projects that will help patients become more engaged in their own care and address one of the SIM Initiative’s health focus areas	<ul style="list-style-type: none"> • Contracts awarded for projects in September 2017. • Complex Care Conversation Project: By February 2018, trained 95+ providers in Complex Care Conversations to improve palliative care communication. • Advance Care Planning Training Program: Developed a curriculum for patients and providers on advanced care planning; convened public meeting in March 2018 on holding end-of-life conversations with loved ones. • Consumer Engagement Platform: Obtained stakeholder input to design platform enabling consumers to upload advance directives and responses to screeners into the state’s HIE. • Conscious Discipline Program: Began to implement Conscious Discipline in 3 schools to better engage students with social-emotional challenges in learning.

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APCD = all-payer claims database; BH = behavioral health; CHT = community health team; CMHC = community mental health center; eCQM = electronic clinical quality measure; health IT = health information technology; HIE = health information exchange; IBH = integrated behavioral health; PCMH = patient-centered medical home; PCP = primary care provider; PediPRN = Pediatric Psychiatry Resource Network; SBIRT = Screening, Brief Intervention, and Referral to Treatment; SIM = State Innovation Model; SSD = Social Services Directory; TA = technical assistance; VBP = value-based payment.

Quality measure alignment

As of November 2017, the Measure Alignment Workgroup transitioned from a SIM-supported subcommittee to a work group under OHIC's authority. The measure alignment work initiated by the SIM subcommittee work was already incorporated into OHIC's ongoing operations, supported by a regulation requiring that all commercial payers use the Aligned Measure Sets in any contract with a financial incentive tied to quality. This regulation required OHIC to convene the Measure Alignment Workgroup on an annual basis to review and update the Aligned Measure Sets as necessary. Updated guidance on the use of aligned measure sets and applicable contracts for use of the measure set was published in November 2017.¹⁰

Payers, providers, and state officials pointed to quality measure alignment as one of the SIM Initiative's major successes, because it helped decrease administrative burden for payers in contract negotiation and providers in data collection. One payer reported that the Measure Alignment Workgroup was an excellent example of SIM leadership's inclusion and engagement of payers in SIM decision-making processes. The payer went on to say that the alignment process served to decrease burden on providers and recalled that, before the alignment process, some of the larger providers were reporting on more than 150 quality measures. Another payer remarked that measure alignment had a direct impact on contract negotiations, making negotiating with hospitals, in particular, a bit smoother. Providers also appreciated the decrease in burden associated with working under an aligned core measure set, with one provider expressing gratification that the Medicaid plans agreed to follow the core measure set in the future.

Stakeholders saw alignment with Medicare and inconsistent EHR data quality as remaining challenges. Providers commented on difficulties in aligning measures with Medicare, because some Medicare measures were not up to date with changes implemented in the Healthcare Effectiveness Data and Information Set (HEDIS) and National Quality Forum (NQF). Some state officials and providers expressed concerns about the quality of data used to produce quality measures. One provider indicated that not all EHR systems provide data in a manner that providers felt was comparable and that, although the data could be used to help practices improve over time, cross-practice comparisons were less certain.

Health information technology strategies

The SIM Initiative continued its strategy to increase analytic capabilities to support APMs through APCD, the electronic clinical quality measure (eCQM) reporting and feedback

¹⁰ OHIC. (2017, November 3). *Updated guidance on use of aligned measure sets*. Retrieved from <http://www.ohic.ri.gov/documents/Aligned%20Measure%20Set%20Interpretive%20Guidance%202017%2011%2003.pdf>

system (also known as the health care quality measurement reporting and feedback system), and the integrated health and human services data ecosystem.

The APCD was helpful in evaluating and showing the effectiveness of SIM-funded programs. The state provided a workshop regarding the APCD during a vendors’ meeting to increase vendor understanding and utilization of this resource. State officials reported receiving requests for APCD data to evaluate the quality of care. For example, APCD data uses involved providing risk-adjusted and unadjusted utilization, cost, and quality measures for all CTC cohorts, including IBH and PCMH-Kids. A state analysis of data obtained in July 2017 and December 2017 indicated, as noted, that the IBH pilots had fewer inpatient stays and specialist visits than the risk-adjusted statewide comparison group. Additionally, all CTC cohorts had lower PMPM for total cost of care/pharmacy compared to the risk-adjusted comparison group.

Rhode Island selected a vendor to refine and implement the eCQM reporting and feedback system and the integrated health and human services data ecosystem projects. The state made a conscientious effort to exercise caution in pursuing these projects and engaged in an extensive review process for both. As an example of the time invested in developing and vetting these procurements, the request for proposals for the eCQM reporting and feedback system was closed in March 2017; however, the contract for the vendor, IMAT Solutions, Inc., was not finalized until January 2018. One state official said the process of planning for the eCQM reporting and feedback system—a Web-based portal to access quality measure data—was further challenged, because it required collecting health information exchange (HIE) and EHR data. The state’s procurement process prevented early planning and communication with the vendor and other stakeholders around accessing the data for the system; however, as of March 2018, the conversations around data access were progressing.

State officials perceived the integrated health and human services data ecosystem as valuable in using data analytics to address cross-agency policy issues, such as the impact of reducing congregate care capacity for children. Rhode Island identified two state

“To me, the ability to bring in the human services data in a relational database, the ability to use that for predictive modeling for early intervention is tremendous. That could be a transformational analytical capacity.”
—State official

partners to provide data integration and analytic support. An external vendor, Abilis, was also identified to support data modeling and optimization. The integrated health and human services data ecosystem governing body received more than 30 potential use cases for the ecosystem of which they identified three projects for the initial use cases—1) individuals with Alzheimer’s disease or dementia, 2) veterans, and 3) children under 7 years of age who have experienced maltreatment.

State officials and providers offered positive feedback on the care management dashboards, with providers reporting a positive impact on consumer care. Providers who

used the dashboards extensively in their practices shared many specific observations about the mechanics of the dashboards and how they affected consumer care—that CMHC dashboard implementation progressed smoothly, that the SIM-supported training was good preparation for dashboard use, and that the dashboards had impacted how providers coordinated care. Some said timely notification that consumers were in the hospital enabled better managing schedules, enabling providers to meet with consumers in the hospital and better coordinate their post-hospital care. A few providers mentioned being able to make hospital visits to the consumers on their caseload for whom they had received evening and weekend alerts. Some providers shared positive impressions from consumers about the dashboard, with a few consumers expressing surprise at how quickly their social workers knew they were in the hospital.

State officials and other stakeholders described the statewide common provider directory as a potentially valuable tool for providers and patients, but that the project faced some software and data quality challenges. A significant software issue, coupled with concerns about data quality, caused some delays on the project rollout, resulting in the state’s decision to reevaluate the project during the AR3 analysis period and, with CMS permission, to conduct a feasibility assessment of the directory. The state also considered other use cases for the directory, such as a social services section, which the state believed would be very useful for both providers and patients.

The provider directory project offered the state an opportunity for some lessons learned—primarily ensuring buy-in for the project from customers throughout development and ensuring the appropriate data level and accuracy needed to build trust in the resource. According to state officials, when discussions regarding the directory began, many stakeholders supported its development; however, it was not yet clear how customers would implement or use the directory. Also, state officials noted that decisions regarding how to maintain the accuracy of the provider directory should have been made earlier in the project development. Directory data came from multiple sources, the quality of which varied greatly by source, but validating and updating provider directory data was cost prohibitive. State officials agreed that developing a solid business use case prior to investing in a new project was an important lesson learned.

As an outgrowth of the population health work supported by the SIM Initiative, the state added a new health IT project in November 2017, working with several health and human services agencies to develop a Unified Social Services Directory (SSD). SIM funding was allocated for this project to eliminate duplication of effort by providing a single source of social services information, rather than each social service agency using a different resource database. The state planned to use its existing 2-1-1 infrastructure for the new database.

During 2017, support for the state’s APCD, HealthFacts RI, transitioned from SIM funding to other state and federal funding sources. The state had leveraged SIM TA funding

to investigate how to use implementation advanced planning documents (IAPDs)¹¹ to support the APCD. State officials report the APCD is now sustained through revenues from data sales and state matching dollars, and the state plans to use similar strategies to support other health IT projects, such as the state health data ecosystem.

Practice transformation and workforce projects

In October 2017, Rhode Island contracted with the CTC of Rhode Island to establish new community health teams (CHTs), support existing CHTs, and implement SBIRT in clinical and community settings, a project that braided SIM funds with Substance Abuse and Mental Health Services Administration (SAMHSA) grant funding. SIM funding supported the CHTs, including the teams' SBIRT implementation. One provider acknowledged the two funding sources but described the effort as a single project that both expands the number of CHTs and strengthens all CHTs' ability to identify and address behavioral health needs. Three state officials, although expressing optimism that this approach would create efficiencies and help them identify best practices in CHT operations, felt it was still too early to see whether that would actually happen.

"SBIRT is so exciting because it's a deeper integration; a way to start leveraging primary care to meet mental health needs."

—State official

As of March 2018, eight CHTs were benefiting from the consolidated support. Four teams were in place before the project began—two new SIM-funded teams and two new teams created without SIM funding. One of the new non-SIM-funded teams was funded through OHIC by an insurer that missed a primary care target set by the Insurance Commissioner. All eight teams were in operation and meeting monthly to share experiences and expertise. The teams are also using a Web-based platform for project management, shared learning, and information awareness. They are beginning to collect the same performance data across teams and were hoping to align assessments for social determinants of health needs. Both state officials and a CHT reported that all CHTs benefited from this project, but especially the new CHTs, which can learn how more established CHTs have successfully navigated issues, such as establishing agreements with primary care practices, engaging patients, and producing performance metrics.

"Most of the new CHTs agreed that they really benefited from having expertise from those partners that were established for a while There was a streamlined ship for the other CHTs that were just beginning."

—State official

A few interviewees expressed concern about the sustainability of the SIM-funded CHTs because of the brief time available to prove the CHTs' value. Delays in the

¹¹ States can access 90 percent federal matching funds through Health Information Technology for Economic and Clinical Health (HITECH) administrative funding for HIE activities. Requests for funding require submission of an IAPD to CMS that shows how the state's HIE would support shared medical record access across providers and facilitate community-based providers use of EHRs.

procurement process and the administrative challenges of weaving together two separate awards from two different funding sources delayed contract award—this resulted in significant delays in the production of SAMHSA deliverables. As a result, the CHT/SBIRT project initially had to prioritize SBIRT screening over CHT development, causing further delays in the launch of the SIM-funded CHTs.

Rhode Island launched the SBIRT Training and Resource Center in October 2016 to train providers to identify substance use disorder. As of March 2018, according to state officials, the center had trained more than 700 providers. The center also conducted training on special topics, such as Assertive Community Treatment. Providers spoke highly of the training, although one provider reported not yet having been able to train all its sites. State officials were particularly pleased about the center’s reach, reporting that the center had trained a broad range of clinicians, including dentists and students who will be entering the health care workforce.

Providers continued to express support for PediPRN and value the assistance it offered pediatricians.

According to state officials, as of March 2018, some 336 providers from 56 practices were enrolled in PediPRN, and 415 mental health consultation calls had been made. In late 2017, this contractor offered pediatric PCPs continuing medical education for participation in a 3-day, in-person training event that addressed critical aspects of treating: (1) depression in youth, (2) attention deficit hyperactivity disorder, and (3) pediatric anxiety disorders and obsessive-compulsive disorders. In late 2017, the SIM Steering Committee awarded PediPRN additional funding to provide school staff and pediatric providers with training on how to recognize and meet the needs of youth in crisis, including those at risk for suicide.

“PediPRN ... has worked beautifully to expand the workforce.”
—State official

Finally, in March 2018, Rhode Island launched its final workforce/practice transformation project, securing a contractor to provide coaching and staff development to all licensed behavioral health providers in the state.

Expansion projects from unexpended State Innovation Model funding

Primarily because it brought project management tasks in-house in early 2018, Rhode Island identified savings from unexpended funds from the SIM Initiative. After discussion with the steering committee and with CMS approval, the state decided to use the funding to expand existing SIM contracts and make some new investments that stemmed from the state’s initial work on practice transformation and workforce. The unexpended funds were allocated to (1) PediPRN expansion, (2) linkage with Health Equity Zones (HEZ), (3) SBIRT practice support, (4) a Community Preceptor Program for students studying to become community-based health care and social services providers, and (5) expansion of end-of-life training.

I.2.4 Population health

Key Results

- The SIM Initiative facilitated collaboration among hospitals and the United Way to develop the Unified SSD, which will facilitate e-referrals, track high-risk patients, and integrate social services health information.
- An analysis of tobacco cessation benefits covered by insurers integrated into SBIRT training.

During the AR3 analysis period, the SIM Initiative issued the first component of the State Health Improvement Plan and began implementing three integration and alignment projects. Through work on one of the projects the SIM Initiative also identified the need for a Unified SSD to help providers address the social determinants of health. In late 2017, the SIM Steering Committee resourced RIDOH to align the work of the agency's HEZ Initiative¹² with SIM projects. Although interviewees were confident the alignment would produce improvements in population health, interviewees were unsure whether measurable outcomes would occur before the SIM Initiative's end (*Table I-6*).

State Health Improvement Plan

In July 2017, the state issued its first *Health Assessment Report*.¹³ Rhode Island plans to complement this document with three other reports focused on (1) describing the population health goals and strategies, (2) assessing progress toward the goals, and (3) measuring impact. The state planned for these documents to communicate information from the State Health Improvement Plan to a broader audience to assist with health planning in the state. These documents are intended to be living documents, regularly updated to reflect changing needs, strategies, and progress. Several interviewees mentioned that the SIM Steering Committee might change its focus to work on health planning after the end of the SIM award. Then, the State Health Improvement Plan would be key in the ongoing planning process.¹⁴

"...people are thinking about the need to define what are our system needs into the future and then deciding on a set of principles to guide individual decisions that state leaders will make as they go forward."

—State official

¹² RIDOH funded 10 HEZ communities in 2018. Each HEZ community developed (or was in the process of developing) an assessment of its community and a strategic plan to establish infrastructure aimed to increase community health. Next, the HEZ communities will enact their strategic plans within their respective communities.

¹³ EOHHS. (2017, July 28). *Rhode Island State Health Improvement Plan. Component A: Health Assessment Report*. Retrieved from <http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/SIM/SIMHealthAssessmentReport7-28-2017.pdf>

¹⁴ The state submitted a revised version of the State Health Improvement Plan within later versions of the Rhode Island SIM Operational Plan.

Table I-6. Rhode Island’s progress on population health

Activity	Target population	Key activities	Progress between May 1, 2017, and March 31, 2018
State Health Improvement Plan	People experiencing a condition in one of eight health focus areas	Develop and maintain a State Health Improvement Plan	<ul style="list-style-type: none"> • Issued <i>Health Assessment Report</i> in July 2017. • Issued a Revised State Health Improvement Plan as part of the AY3 SIM Operational Plan.
High-risk patient identification	High-risk adults and children and the providers who serve them	Developing consensus on how to define and identify “high-risk” adults and children; increasing provider capacity to respond to identified needs, especially social services needs	<ul style="list-style-type: none"> • Surveyed existing approaches to identifying and meeting the needs of high-risk patients, especially social determinants of health needs. • Selected 12 common social determinants of health domains to which questions in various screening tools could be mapped. • Decided to pilot the Unified SSD to help connect health and social services providers. • Transferred lead from OHIC to the SIM core team in July 2017.
Tobacco assessment referral and treatment	People who smoke	Promote alignment among state agencies, payers, providers, and others to provide cessation services and understand the benefit structure and utilization across public and private payers	<ul style="list-style-type: none"> • Developed matrices to summarize health plans’ cessation coverage to help providers secure services for patients; planned dissemination. • Working to embed Quitworks, a provider referral system, in health IT platforms. • Included tobacco cessation in SBIRT training and provider coaching requests for proposals. • Transferred lead from SIM core team to RIDOH in early 2018.
Statewide BMI data collection	Children	Building infrastructure for real-time, de-identified statewide BMI data repository based in existing state capacity	<ul style="list-style-type: none"> • Tested a data collection process on a small scale, planned to write a policy brief outlining findings and next steps.

AY = Award Year; BMI = body mass index; health IT = health information technology; OHIC = Office of the Health Insurance Commissioner; RI = Rhode Island; RIDOH = Rhode Island Department of Health; SBIRT = Screening, Brief Intervention, and Referral to treatment; SIM = State Innovation Model; SSD = Social Services Directory.

Integration and alignment projects

Interviewees continued to express strong support for the three integration and alignment projects (Table I-6), and several credited that support to the project selection process. State officials believed the improvements and products produced by these projects (e.g., the tobacco matrixes produced by the Tobacco Assessment, Referral, and Treatment project) would be maintained after the end of the SIM award, because of their ongoing usefulness to state agencies and other organizations.

The High-Risk Patient Identification Project has been modified. Rhode Island had originally intended to develop a consensus definition of high risk and identify a standardized assessment tool that would be used broadly. However, over the past year, Rhode Island has concluded that it will not be possible to select a single assessment tool because of the variety of tools already used in Rhode Island and users' reluctance to change tools. Instead, SIM staff are now pursuing alignment on 12 domains, including food insecurity, housing instability, and financial resource strain/income. Project planners believe that all screeners currently in use in Rhode Island ask questions that surface patient needs in these 12 domains. Identifying which questions in each screener address these issues will enable Rhode Island to develop a single system to respond to needs identified by a variety of screeners.

Rhode Island found that a major barrier to providers screening for social determinants of health was providers' lack of knowledge about how to meet the identified needs. SIM staff determined that Rhode Island's two largest hospitals were working to develop a database that would help overcome the knowledge barrier. Using the convening resources of the SIM Initiative, Rhode Island facilitated a collaboration among these hospitals and the United Way of Rhode Island to develop the Unified SSD, which would draw on the provider directory to facilitate e-referrals, track high-risk patients, and integrate social services health information.

Interviewees were confident that the SIM Initiative would complete the three integration and alignment projects before the end of the SIM award. Interviewees were optimistic that the SIM Initiative's population health approach would improve the delivery of care including, ultimately, measurable outcomes in the three population health focus areas. However, stakeholders noted that the SIM Initiative focused primarily on the health system and that "90 percent of your health is determined outside the clinic." Uncertainty remained that measurable population health improvements would occur before the SIM award ends in 2019, because of the time it takes to produce such outcomes and the metrics that confirm improvement.

I.2.5 Governance and sustainability

The SIM Steering Committee established a work group in late 2017 to work on SIM sustainability. As of March 2018, the work group had met twice. Interviewees reported that the broad representation among committee members enabled the SIM Initiative to align and integrate SIM projects with other initiatives in the state. Alignment and integration through their “culture of collaboration,” they report, not only strengthen projects conducted during the SIM award period but also provide for sustainability by increasing the likelihood that an organization will continue the effort as part of its ongoing operations.

“... with the right people in the room you can really make progress. I think that would probably be one of the strongest legacies that SIM will have.”

—Payer

Interviewees valued the SIM Steering Committee so highly that both state officials and other stakeholders spoke about the possibility of continuing the committee after the SIM Initiative ends. Stakeholders suggested that perhaps the committee could continue by shifting its focus to statewide health planning. However, one interviewee was doubtful that the committee could be repurposed and still sustain the previous level of stakeholder engagement.

I.3 Implications of Findings/Lessons Learned

The SIM Initiative achieved several major milestones during the AR3 analysis period:

- The SIM Initiative made additional progress aligning its vision for delivery system transformation with Medicaid.
- Individuals with behavioral health conditions presenting at emergency departments experienced increased care coordination through increased communication between their behavioral health therapists and hospital staff.
- The state identified specific strategies for meeting preponderance of care targets such as convening work groups to discuss barriers to APM adoption and targeting physicians practicing with an ACO.
- SIM leadership increased the importance placed on evaluating SIM investments and demonstrating a return on investment (ROI) whenever possible.
- Investment in APCD analytics was beginning to show the effectiveness of SIM delivery reform activities.
- Three integration and alignment projects were implemented to improve population health among high-risk patients, smokers, and children.
- Formation of a sustainability work group during the AR3 analysis period demonstrated the state’s commitment to sustaining impactful SIM investments.

Based on the SIM implementation experience, stakeholders offered several opportunities, remaining challenges, and lessons learned for other states:

- Pre-SIM policy levers (e.g., affordability standards) were effective in moving provider payment further along the VBP continuum within the SIM Initiative.
- Investing decision-making authority in the Steering Committee at first slowed implementation but ultimately facilitated implementation, operations, and sustainability by creating stakeholder ownership of the SIM Initiative and its projects.
- OHIC, which regulates health insurance, used regulation and its relationships with health plans to engage plans as active (and sometimes funding) partners in the SIM Initiative.
- The SIM Initiative's strategy of advancing health system reform via integration and alignment broke down barriers between health care initiatives and state agencies, enabling Rhode Island to spark, and likely maintain, improvements begun under the SIM Initiative.
- The short testing period did not allow adequate time for the state's lengthy procurement process or for observation of longer-term health outcomes.
- Rhode Island partially mitigated the challenge of a short testing period by investing in projects already implemented or in development at the time of the SIM award.
- Most providers were eager to receive the practice transformation support offered by the SIM Initiative, but a few remained resistant to new payment models and uninterested in practice transformation.
- The SIM Initiative did not initially realize the importance of developing a strong business case for health IT investments but ultimately realized its importance and increasingly focused on assessing users' needs during project design.

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Appendix J: State Innovation Model in Model Test States: Tennessee

Key Results from Tennessee's State Innovation Model Initiative May 2017–March 2018

Strategies, progress, and accomplishments, May 2017–March 2018

- Episodes of care (EOCs) Waves 1 through 6, involving 29 individual episodes, were implemented in Tennessee's Medicaid program, TennCare.
- Downside risk was removed from the EOC model for the state employee and commercial markets, making the model more palatable to providers.
- The SIM Initiative added 39 patient-centered medical home (PCMH) practices and 1 Health Link practice, a program for TennCare beneficiaries with acute behavioral health issues, in January 2018, bringing the totals to 67 PCMH practices and 22 Health Link practices.
- The value-based payment (VBP) model and new quality metrics for Enhanced Respiratory Care (ERC) provided by nursing facilities (NFs) reduced costs and improved patients' quality of life.
- Successful implementation of the Employment and Community First (ECF) CHOICES managed long-term services and supports (MLTSS) program resulted in competitive, integrated employment for 17.5 percent of working age enrollees in the program as of March 2018.
- The care coordination tool (CCT) was well accepted and promoted by the Tennessee Hospital Association (THA), resulting in approximately two-thirds of hospitals submitting data.
- Technical assistance (TA) across all strategies facilitated implementation.
- The Department of Health (DOH) finalized a set of 12 population health Vital Signs, was developing quality improvement (QI) logic models, and was building an interactive Web database of Vital Sign QI resources.

Stakeholder response to implemented strategies

- Broad stakeholder involvement in Technical Advisory Group (TAG) meetings aided progress in EOC acceptance among providers.
- Stakeholders were unanimously enthusiastic about the CCT.
- Stakeholder views about the primary care quality measure alignment were mixed.

Remaining challenges

- Although there has been progress in provider acceptance of the EOCs, provider buy-in remains challenging.
- The Health Link focus on connecting beneficiaries with primary care might take time away from addressing beneficiary's social needs and community integration.

Sustainability after the SIM award

- The sustainability of the EOC model depends on long-term maintenance of episodes.
- Medicaid managed care organizations (MCOs) will contractually assume post-SIM PCMH oversight responsibility.

Tennessee’s SIM Initiative, known as the Health Care Innovation Initiative, began on February 1, 2015, to make health care in Tennessee a value-based system focused on efficiency, quality of care, and patient experience. To accomplish its goals, the state focused on three overarching strategies: primary care transformation, EOCs, and long-term services and supports (LTSS).¹

This updated overview of the Tennessee SIM Initiative is based on an analysis of data collected from site visits, stakeholder telephone interviews, state document reviews, and state program and evaluation calls during the Annual Report (AR)3 analysis period, between May 1, 2017, and March 31, 2018. Further details on the analytic approach are available in *Chapter 1*. Information on the number and types of stakeholders interviewed for the state is in *Table 1-1*. *Figure J-1* depicts the timeline of major Tennessee SIM Initiative and related activities to date.

J.1 Key State Context and Progress Prior to May 2017

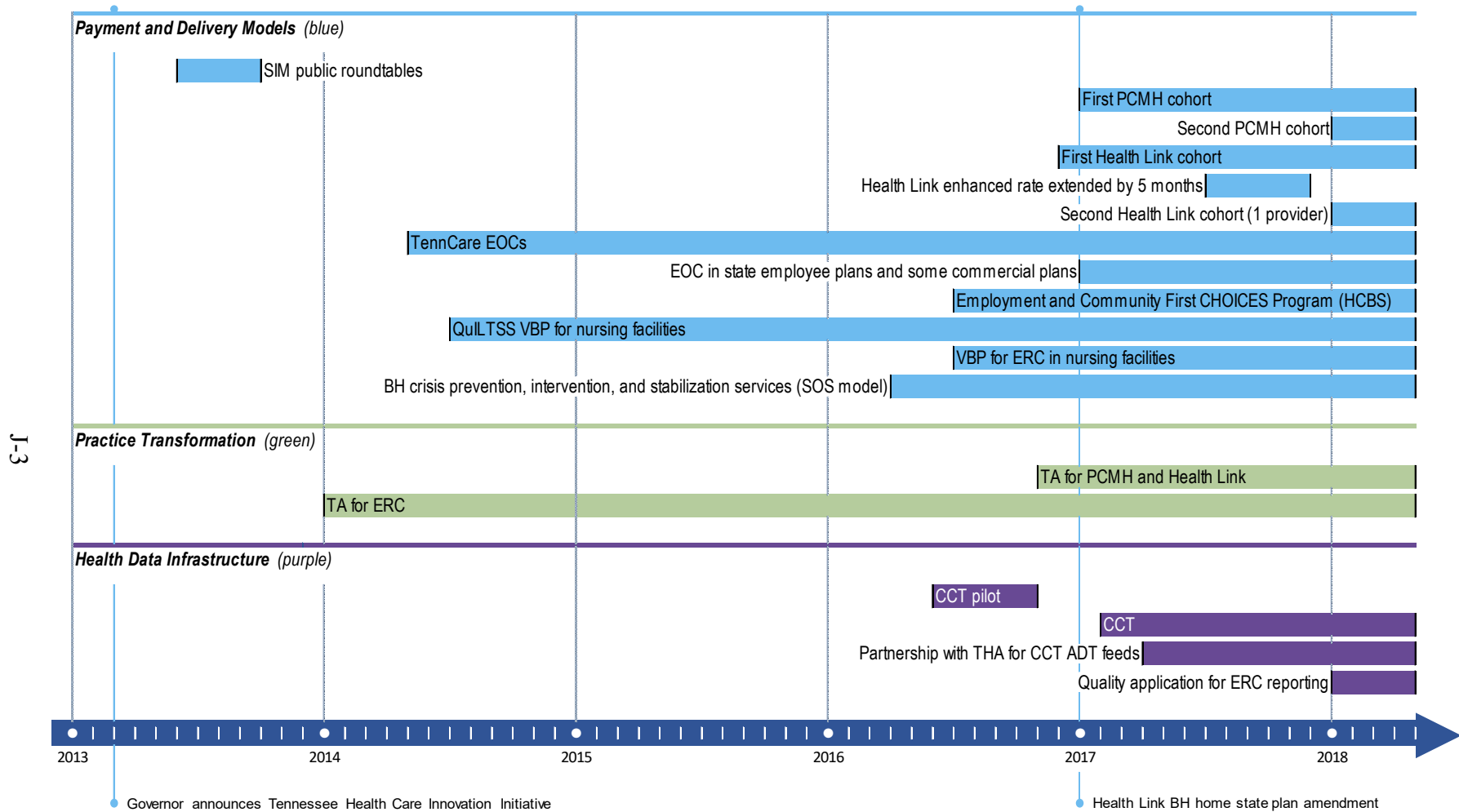
J.1.1 Pre-State Innovation Model health care in Tennessee

Three key features of Tennessee’s health care environment are relevant to its SIM Initiative. First, the state is geographically large, with significant diversity among its urban areas and its large areas of rural communities. Health care delivery varies by region—with large health systems and group practices covering the major metropolitan areas, and Federally Qualified Health Centers and individual practitioners, along with small hospitals, providing care in rural areas. Health systems began implementing geographic and vertical integration strategies before the SIM Initiative.

Second, the state has significant health needs, with Tennesseans having higher than national rates of self-reported poor/fair health, diabetes, cardiovascular disease and/or asthma, obesity, and tobacco use. Tennessee ranked 47th in the nation on the Five Star Quality Reporting System for nursing homes in 2013. To address the needs of people in long-term care, 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.

¹ Division of TennCare. (n.d.). *Tennessee Health Care Innovation Initiative*. Retrieved from <https://www.tn.gov/tenncare/health-care-innovation.html>

Figure J-1. Timeline of Tennessee State Innovation Model and State Innovation Model-related activities



ADT = admission, discharge, and transfer; BH = behavioral health; CCT = care coordination tool; EOC = episode of care; ERC = Enhanced Respiratory Care; HCBS = home- and community-based services; PCMH = patient-centered medical home; QuILTSS = Quality Improvement in Long-Term Services and Supports; SIM = State Innovation Model; SOS = System of Support; TA = technical assistance; THA = Tennessee Hospital Association; VBP = value-based payment.

Third, TennCare has been predominantly a managed care program since 1994—with three MCOs (Blue Care, UnitedHealthcare, and Amerigroup) providing services to most enrollees. Tennessee contracted with its TennCare MCOs to provide behavioral health, physical health, and long-term care services—a long-established relationship enabling the state to work collaboratively and contractually in effectuating reform. TennCare’s three MCOs have managed two MLTSS programs since their inception: the ECF CHOICES program launched in 2010, and the Employment and Community First program launched in 2016.

Fourth, Tennessee’s efforts to change health care delivery and payment were fragmented prior to the SIM Initiative, with multiple primary care reform initiatives taking place within specific regions and MCOs. Some commercial payers and Medicaid MCOs implemented PCMH pilots, but these programs varied in size and scope and were not widespread. Numerous stakeholders described the MCOs as operating independently of one another, rather than collaboratively. TennCare’s interest in further PCMH reform and in adopting an episode-based payment model was deepened by its participation in a THA taskforce that also included providers and payers considering options to address federal and state payment cuts.

J.1.2 State Innovation Model Initiative progress and changes prior to the Annual Report 3 analysis period

Tennessee’s SIM Initiative was built on three models—primary care transformation, EOCs, and LTSS. All of these were implemented prior to the AR3 analysis period.

Primary care transformation strategies were implemented on schedule. Tennessee’s three-pronged strategy for promoting the role of the primary care provider (PCP) in managing chronic disease and delivering preventive services included (1) PCMHs that were implemented in January 2017 with 29 practices; (2) health homes for high-risk TennCare beneficiaries with acute behavioral health needs, known as Health Link, that was implemented in December 2016 with 21 practices; and (3) a provider CCT that included admission, discharge, and transfer (ADT) data for attributed PCMH and Health Link providers that was implemented in January 2017. The state implemented all components of the primary care transformation strategy on schedule.

EOC Waves 1 through 4 were implemented during the AR2 analysis period, comprising 19 individual episodes. Waves 1 and 2 were in the accountability period, Wave 3 was in the performance period, and Wave 4 was in the preview period.² For each episode, prior

² Implementation of each EOC begins with a preview period, during which providers receive actionable cost and quality data but are not held financially liable for their performance on the episodes. The goal of this period is to allow providers sufficient time to adjust their behavior. The calendar year following the year in which the preview period began is known as the performance period. During this time, providers are eligible for gain- and risk-sharing, based on their management of cost and quality of care for the designated episodes. Payment calculations are made after the performance period ends, during the accountability period.

to the preview period, the state gathered feedback on episode design and reimbursement from relevant providers and payers through a series of structured, in-person TAG meetings. The TennCare MCO contract mandated that plans incorporate EOCs into their payment methodologies, yielding full participation. The greatest EOC implementation challenge in the commercial market was pushback from providers, who were very resistant to mandatory participation. For the state employee health plan on the commercial side, the two carriers participated, although participation by their providers was voluntary in the 2017 contract year. State officials had frequent discussions with carriers, providers, and the legislature during the latter months of the AR2 analysis period to discuss potential modifications to the model, including removal of downside risk in the commercial market, to address provider concerns and increase participation.

Tennessee leveraged its SIM Initiative to expand the use of VBP in its Medicaid LTSS program. This activity included strengthening the QuILTSS program for NFs, starting in late 2013 to engage stakeholders and continuing with QI activities in 2014 to provide more choice and increase satisfaction for NF residents. The state had planned to implement prospective payments for NFs based on quality in January 2017, but this shift was delayed by a lengthy rate change process.

Implementing QuILTSS for home- and community-based services (HCBS) providers was more challenging, because of the large number and diversity of providers involved. The exception to this was the ECF CHOICES program, which was implemented in July 2016 to serve individuals with intellectual and developmental disabilities (I/DD) by promoting employment and community living—with VBP methodologies built into the model.

During 2016, the state also implemented the Behavioral Health Crisis Prevention, Intervention and Stabilization program, commonly known as System of Support (SOS), to reduce behavioral health crises among individuals with I/DD. Early 2017 results showed dramatic improvement in hospital diversion, reduced use of psychotropic medications, and an increase in integrated employment and community activity participation and engagement in meaningful relationships.

LTSS payment reform in the ERC program, implemented in July 2016, incorporated new quality metrics into the payment methodology for beneficiaries receiving ERC services in NFs. State officials expected these changes to result in profound quality improvement for tracheotomized and ventilator-dependent TennCare beneficiaries, along with significant cost savings.

Tennessee encouraged strong stakeholder participation in the design of their SIM program. State officials, providers, and other stakeholders all viewed the SIM Initiative as an opportunity to improve primary care and implement payment reform. By the end of the AR2 analysis period, Tennessee's SIM Initiative had successfully engaged TennCare providers in

transformation efforts and was collaborating with the commercial sector to address its concerns as part of the ongoing shift toward value-based care.

J.2 Progress and Accomplishments from Tennessee’s State Innovation Model Initiative, May 2017–March 2018

J.2.1 Delivery models and payment reforms

Key Results
<ul style="list-style-type: none">• A second wave of 39 additional PCMH practices and one additional Health Link practice came online in January 2018.• Twenty-nine individual EOCs were implemented in TennCare.• EOC participation by state employee and commercial providers remained voluntary with no downside financial risk.• The VBP model for NFs providing ERC reduced costs and improved patients’ quality of life.• By March 2018, the implementation of ECF CHOICES assisted 17.5 percent of working-age program enrollees in securing competitive, integrated employment.

Tennessee maintained its SIM implementation momentum and successfully met its milestones. Payer, provider, and consumer stakeholders praised the state’s leadership and the level of dialogue, receptivity to input, and collaboration the state fostered (*Table J-1*). Thirty-nine PCMHs came onboard in January 2018, resulting in a total of 67 participating PCMH practices. One additional Health Link practice was added in January 2018, bringing the total number of participating Health Link practices to 22. Approximately two-thirds of hospitals in the state submitted ADT data for the CCT. Twenty-nine EOCs were implemented in TennCare; a more limited number of EOCs was implemented on the commercial side. Commercial sector resistance to EOCs diminished somewhat because participation remained voluntary, and financial “downside risk” will not be implemented on the commercial side. A revised quality- and acuity-based NF prospective per diem payment structure was in the rulemaking stage, with an anticipated start date of July 2018.

Table J-1. Tennessee’s progress on delivery system and payment reforms

Activity	Target population	Key activities	Progress between May 1, 2017, and March 31, 2018
EOCs	Providers	EOC implementation in TennCare, State Employee, and Commercial Plans	<ul style="list-style-type: none"> • Twenty-nine EOCs were implemented in TennCare, with EOC participation mandatory for providers and both gain-sharing and downside risk. • The two state employee health plans are implementing EOCs. Provider participation in state employee EOC and commercial plans in 2018 remains voluntary with gain-sharing and no downside risk.
Primary care transformation	TennCare MCO enrollees	PCMHs	<ul style="list-style-type: none"> • Added 39 PCMH practices for a total of 67 PCMH practices in January 2018.
	PCMH Providers	PCMH payment reform	<ul style="list-style-type: none"> • PCMH providers received practice transformation incentive payment and risk-adjusted PMPM payment and were eligible for annual bonuses based on quality and efficiency metrics.
	Health Link Providers		<ul style="list-style-type: none"> • Added one Health Link provider in January 2018. • Health Link provided services to 55% of attributed TennCare beneficiaries.
	Health Link Payment Reform		<ul style="list-style-type: none"> • Health Link providers received payments for care coordination services and were eligible for annual bonuses based on quality and efficiency metrics.
LTSS	TennCare NF residents	NF QI	<ul style="list-style-type: none"> • 82% of NFs offered residents quality of life choices, such as meal times, sleep hours, etc. • Large reductions were made in the use of antipsychotics for long-stay residents. • Increased the number of facilities with 100% of staff trained in the CMS Hand-in-Hand curriculum.
	NFs providing ERC	ERC	<ul style="list-style-type: none"> • Implemented a quality application to streamline provider data reporting and make feedback immediately available.
	Individuals with I/DD	ECF CHOICES	<ul style="list-style-type: none"> • Positive employment outcomes were reported for participants in ECF CHOICES MLTSS.
	HCBS providers	1915(c) HCBS waivers	<ul style="list-style-type: none"> • Worked with HCBS providers on VBP for 1915(c) waivers for individuals with I/DD.

CMS = Centers for Medicare & Medicaid Services; ECF = Employment and Community First; EOC = episode of care; ERC = Enhanced Respiratory Care; HCBS = home- and community-based services; I/DD = intellectual and developmental disabilities; LTSS = long-term services and supports; MCO = managed care organization; MLTSS = managed long-term services and support; NF= nursing facility; PCMH = patient-centered medical home; PMPM = per member per month; QI = quality improvement; VBP = value-based payment.

Primary care transformation

Tennessee’s SIM Initiative continued implementation of PCMHs, and Health Link is an important foundation of the state’s health care delivery system. A second cohort of 39 PCMH practices began in January 2018, for a total of 67 PCMH practices. Health Link added a 22nd practice, also in January 2018. CCT adoption among PCMHs and Health Link, with Navigant providing training to support its use, had a profound impact on identifying and closing health care gaps—by aiding in coordinating care and directing needed resources to patients. Both the CCT and Navigant’s training are discussed in greater detail in *Section J.2.3*.

Interviewees cited the state’s work in advancing PCMHs as a major success. PCMH participation is encouraged through payment reform, with a practice transformation incentive and risk-adjusted per member per month payments, as well as eligibility for annual bonuses based on quality and efficiency metrics. State, payer, and provider stakeholders stated that the second round of PCMH recruitment and implementation went even more smoothly than the first round, as a result of having the necessary infrastructure in place, having Navigant on board to provide technical assistance to providers, and having the CCT available to PCMH practices. Accreditation by 2019 from the National Committee for Quality Assurance (NCQA) was set to be a PCMH requirement. To support practices in attaining NCQA PCMH accreditation, Navigant is providing in-person, one-on-one assistance; coaching sessions; and learning collaboratives.

Health Link providers were well positioned to identify beneficiaries’ needs and help them access primary care. Health Link continued to integrate primary care with behavioral health for Medicaid beneficiaries with severe and persistent mental illness and significant behavioral health needs. As of March 2018, over 75,000 (55 percent) of the 137,000 Medicaid beneficiaries attributed to Health Link providers received Health Link services. Stakeholders considered this rapid enrollment of eligible and attributed beneficiaries a

“It’s early for results, but anecdotally, there are big changes in providers who used to do care coordination around member’s behavioral health needs and maybe around social supports, and that’s it. If they started talking about diabetes, ‘that’s not my job.’ Now they understand that connecting to primary care is really important.”

—State official

significant achievement, particularly given the challenges of locating beneficiaries, as many were transient and might not want to be contacted. A state official described Health Link providers as often having good rapport with beneficiaries, who tended to be more comfortable using community-based behavioral health services and did not access primary health care services. Health Link’s case managers—often social workers or nurses—worked with these clients to coordinate their health care services. According to one Health Link provider, “Before Health Link, there was a much more passive process, where clients would just see the social workers if we made a direct referral to them for social needs. But now it’s a much more proactive process, where the social workers are really trying to grab them and make sure they get connected to their primary care provider.”

“Patient-centered medical home. Really, a philosophy of health care that kind of—the way that I view it, it really empowers the patient to be the primary driver of care. So it’s kind of set up so there’s—like a hub where, instead of a patient traveling to multiple health care clinics for care, it’s more of a centralized way to manage an individual person’s health care.”

—PCMH provider

Beneficiaries’ primary care needs were addressed by Health Link providers, but this might have reduced assistance with traditionally received social services.

Health Link psychiatrists, psychiatric nurses, and therapists attending a provider focus group said they had observed a new emphasis on connecting members with PCPs or setting up appointments, if they already had one; making sure they went to those appointments and received the care they needed; helping them get their medications and take them correctly; and adopting healthy behaviors, such as smoking cessation, diet, and exercise. However, several expressed concern that case managers and social workers were no

longer either providing or being paid for services they used to provide, such as helping people find housing, transportation, and food stamps.

Staged EOC implementation continued in TennCare and state employee and commercial payers. By March 30, 2018, EOC Waves 1 through 6 were implemented in TennCare, comprising 29 individual physical and behavioral health episodes. Of these, 19 episodes were in the performance period, and 10 were in the preview period. An additional 21 episodes—comprising Waves 7, 8, and 9—were in the design stage as of March 2018. Waves 7 and 8 had finished the TAG process, and Wave 9 was in the middle of TAG meetings. These episodes were scheduled to enter the preview period after March 2018. By the end of 2019, TennCare planned to have 75 episodes in some stage of testing. This number could change, however, as the state continued to evaluate the model. One state official said a pause period was being considered, so more resources could be dedicated to analyzing and improving existing episodes. State employee and commercial plans had their own schedule for implementing EOCs and worked with the state benefits administration to determine when and which EOCs would be implemented. Both the state employee and commercial plans were implementing far fewer episodes than the TennCare model, partly because of differing health priorities and benefits provided among their patient populations. One carrier, for example, had implemented four EOCs, in contrast to the 29 EOCs implemented in TennCare.

EOC expansion into commercial markets remained voluntary and without downside risk. After delaying mandatory expansion into the commercial market in 2017, the state planned to mandate the EOC model by commercial providers in 2018. However, faced with significant provider resistance, the state kept commercial participation voluntary and, in May 2017, removed downside risk from the commercial model. To encourage provider engagement, payers made reports available for all qualifying providers regardless of EOC participation. The two state employee health plans were implementing EOCs but, like the commercial plans, moved forward with voluntary provider participation and upside risk-only models. The state employee plans

were not covering behavioral health episodes, because they carved these services out. In addition, one state employee plan implemented prospective bundled payments, rather than the retrospective TennCare EOC payment structure.

In addition to opposing the downside risk component of the model, providers were concerned about being held financially liable for low-volume episodes, the resources needed to set up and maintain episodes, and the actionability of the EOC reports. Providers also worried about being held accountable for the actions of other providers over whom they had no control. State officials acknowledged these concerns and noted that providers would require time to adjust to the changes inherent in the EOC model.

TAG meetings were integral to EOC acceptance. The state continued to use TAG meetings to engage payers, providers, and Public Health Department staff in EOC development and implementation. The TAG process included multiple in-person meetings per wave, although some providers felt even more discussion time was needed. TennCare officials said the TAG process was instrumental in vetting and revising EOC quality metrics: “[Participants] may not always like the decisions we land on, but they’re at the table in the TAG process.” Providers agreed with this sentiment. Stakeholders felt the state had grown more receptive to provider input over the course of the SIM Initiative by increasingly soliciting and acting on EOC feedback. In addition to TAG activities, the state worked hard to solicit provider feedback through multiple other avenues, including an Annual Episodes Feedback Session held in six cities across the state, and has been responsive in making design changes based on the accumulated feedback.

The EOC model was expected to continue, despite legislative challenges. EOC roll-out progressed along an ambitious schedule, particularly in TennCare, but challenges remained. Several legislative bills were introduced in the current session, including challenges to the downside risk component of EOCs, plus a bill backed by the Tennessee Association of Mental Health Organizations seeking to exclude behavioral health episodes from the model. State officials noted that they were working with the legislature to ensure that the EOC model would continue to move forward.

Establishing strong nonclaims-based quality measures for episodes was an ongoing challenge. The state considered options for establishing quality measures that used data sources other than claims but had challenges identifying data sources that would not burden providers submitting—or the insurance companies taking in—the information. As the state said, “We tried some, those didn’t work, so now we’re rethinking what additional ones might work.”

Whether increased care coordination under the EOC models impacted health and utilization outcomes was too early to tell. Although care coordination was a central aim of the EOC model, evidence of any impact on health care delivery or utilization was limited. State

officials noted anecdotal evidence that (1) some hospitals were seeing decreased asthma exacerbation inpatient admissions from their emergency departments, (2) providers were changing referral patterns, (3) surgeons were using more efficient post-surgical approaches, and (4) cesarean section rates were decreasing and screening rates increasing, which might be related in part to the EOC model.

Some stakeholders criticized the state’s calculations of the projected savings from the EOC model. The state calculated projected program savings using the risk-adjusted cost of the episodes compared to a projected annual medical trend increase of 3.0 percent. This approach projected 2016 savings as approximately \$14 million, primarily because of estimated savings from reduced perinatal episodes (\$10.9 million) and acute asthma exacerbation episodes (\$2.3 million). Criticism of this methodology included one stakeholder’s assertion that the approach overestimated overall savings, because it did not consider program expenditures. The same stakeholder estimated actual (versus projected) shared savings across all providers at less than \$1 million.

Long-term services and supports

The NF QuILTSS made progress in offering quality of life choices to NF residents. Data reported by the state in the AR3 analysis period showed that the number of facilities offering quality of life choices to residents increased from 34 percent in 2015 to 82 percent in 2017, or an additional 139 nursing facilities offering their residents choices in meal times, menus, sleep and wake times, bathing times, and room decor. The state also reported a 35 percent reduction in the use of antipsychotics for long-stay residents between 2014 and 2018.³

State officials worked with stakeholders on developing a prospective payment structure for NFs with more emphasis on quality. The revised prospective payment system originally planned for implementation in 2017 was delayed, as noted, because of the time required to develop the required rate changes. The new structure was intended to increase the portion of the total payment based on quality over time from 4 percent to 10 percent, not including additional quality informed components of the reimbursement structure, as new funding for NF rates became available. The rulemaking process for the new rate structure began in late 2017, with implementation planned for July 2018.

Tennessee officials considered their greatest success with LTSS payment and quality reform to be the ERC program. In late 2017, state officials reported that average ventilator wean and decannulation⁴ rates had improved and that unplanned hospitalization rates had

³ CMS. (2018). *National Partnership to Improve Dementia Care in Nursing Homes: Antipsychotic Medication Use Data Report (July 2018)*. Retrieved from

https://www.nhqualitycampaign.org/files/Antipsychotic_Medication_Use_Report.pdf

⁴ Removing a tracheostomy tube that is no longer necessary.

continued to decline.⁵ In addition to improving care and lowering costs, the program improved individuals' quality of life. For example, some individuals were weaned from their ventilators after being mechanically ventilated for over 2 years.

To further QI efforts with ERC providers, Tennessee implemented an online quality application (QA) to streamline provider data reporting, calculate their quality scores, and make feedback immediately available—enabling providers to see how practice changes affected their scores. In addition to bi-annual external evaluations, NFs reported performance metrics monthly using the QA—with metrics including ventilator wean rates, hospital admissions, and residents with ERC-acquired infections. The QA placed providers in one of three incentive tiers according to their calculated scores across each 6-month performance period, which affected their payment level. State officials hoped that combining this rapid-cycle feedback with value-based reimbursement would help providers adjust care to continue improving outcomes.

“... even some really long-stay people who’ve been on ventilators for years have come off of ventilators and gone home, completely liberated from the ventilator—a huge success in terms of individual patient outcomes. And we’ve saved 25 percent of the expenditures that we were spending on these services. So less money, better quality, greater outcomes for people, success story all the way around, and the facilities are really, really happy.”

—State official

QuILTSS implementation for HCBS providers was more challenging, with one exception. The exception was the ECF CHOICES program, which was implemented in 2016 with VBP methodologies built into the reimbursement model and serves individuals with I/DD by promoting employment and community living. As of March 2018, 1,561 people enrolled in the program were working age (between the ages of 22 and 64). Of those working-age enrollees, 17.5 percent worked in competitive, integrated employment. Additional participants received pre-employment services, designed to help people learn about job possibilities, develop skills for employment success, and take critical steps toward obtaining employment.⁶

The primary challenge in QuILTSS implementation lay in simultaneously implementing QuILTSS for three HCBS waiver programs that also covered services to individuals with I/DD—because of the number and diversity of providers involved and provider concerns about how the proposed changes would affect their business models and finances. HCBS waiver providers came to agreement during the AR3 analysis period on accepting the new reimbursement structure that incentivized desired outcomes; the state moved forward with submitting the

⁵ Tennessee Division of TennCare. (2017, September 26). *Tennessee Health Care Innovation Initiative CMMI Site Visit—Day 2*. Nashville, TN.

⁶ Tennessee Division of TennCare (personal communication, November 14, 2018).

necessary 1915(c) waiver amendments to CMS, so the changes could be implemented. CMS submission was anticipated in July 2018.

Tennessee laid the groundwork for increasing VBP components used for SOS.

Implemented in 2016, this service was intended to reduce behavioral health crises among individuals with I/DD—to reduce emergency room visits, psychiatric hospitalizations, and other out-of-home placements and to reduce use of psychotropic medications. Providers receive a higher monthly case rate during times of intensive assessment, planning, and capacity-building activities, and a lower monthly case rate as other paid or unpaid caregivers increase their ability to prevent or manage crises. The state planned to add outcome-based payments as part of this VBP model, using claims-based and nonclaims-based measures. During the AR3 analysis period, the state laid the groundwork for adding more VBP components by collecting claims-based quality data and beginning development of an online data collection and analysis repository.

J.2.2 Progress toward a preponderance of care in value-based payment and alternative payment models

Key Results
<ul style="list-style-type: none">• EOC models touched most insured populations (TennCare, state employees, and the commercially insured).• Other SIM models are approaching the preponderance of care goal for the TennCare population.• Among beneficiaries attributed to Health Link, approximately 55 percent received Health Link services.• Approximately half of the LTSS population was in a VBP model.• Approximately 16 percent of the TennCare population was in PCMHs.

Based on the state’s steady progress in implementing EOCs, stakeholders were generally optimistic about meeting the preponderance of care goal of moving 80 percent of all patient care into VBP or alternative payment models (APMs). Stakeholder views on whether the state would meet the goal by the end of SIM Initiative varied, however, depending on how the preponderance of care was calculated and the population(s) included in the calculation.

EOC models touched most insured populations (TennCare, state employees, and the commercially insured), with other SIM programs also progressing toward the 80 percent goal. All TennCare members were covered by the EOC program, putting 100 percent of Tennessee’s Medicaid population in VBP. Almost 5 percent of TennCare participated in Health Link, which represents 55 percent participation of the beneficiaries attributed to that model. Approximately 16 percent of the TennCare population were in PCMHs.

Stakeholders questioned whether quickly scaling up to 80 percent was the best approach. One state official questioned whether quickly scaling up to 80 percent was the best

approach for PCMHs: “You’re just inviting more practices in, even if they’re not on board with the program—they want to do more traditional medicine. We could artificially shoot for [80 percent participation] in PCMHs, but I don’t think that’s a great idea.” Health Link’s population reach was limited by the difficulty of locating and engaging the portion of the TennCare population who were attributed to Health Link providers but did not avail themselves of Health Link services.

The TennCare EOC model was adapted for use in state employee and commercial plans. Although the state made significant progress implementing EOCs, provider participation continued to be voluntary in state employee and commercial plans, resulting in slower progress with these payers. Although the state believed it could meet preponderance of care even for these payers, officials thought that goal might not be reached before the end of the SIM test period. As one state official put it, regardless of whether the state met the 80 percent goal, officials were striving toward the widest possible adoption of VBP models throughout the state and were therefore “meeting the spirit of [preponderance of care] in all of our strategies.”

Table J-2 presents available information on the extent to which Tennessee’s population was participating in the SIM payment and health care delivery models as of Award Year 3.⁷ These values were provided by the state in its fourth quarter 2017 progress report to CMMI. All TennCare beneficiaries were eligible for an EOC if they had a diagnosis that triggered an episode. The state reported participation and PCMHs (15.7 percent) and Health Link participation (4.9 percent) for the first time during the AR3 analysis period.

Table J-3 presents the extent to which Tennessee’s payers were participating in the SIM payment and health care delivery models in Award Year 2. In Award Year 1, the state reported EOCs on perinatal, acute asthma exacerbation, and total joint replacement (Wave 1). For Award Year 2, the state is reporting on those plus five additional EOCs (Wave 2). They report that 24 percent of providers were receiving payments for the PCI-N EOC, while only 3 percent were receiving it for the acute asthma exacerbation EOC. However, the perinatal EOC had the greatest number of beneficiaries (22,090) who had triggered an episode. This result is consistent with Award Year 1, in which 20,442 beneficiaries were in a perinatal EOC.

⁷ Because these data values were not verified by CMMI, the RTI team cannot attest to their accuracy.

Table J-2. Populations reached by a value-based payment or alternative payment model in Tennessee, as of Award Year 3 Annual Report

Payer type	SIM models				Landscape	
	PCMHs	Health homes for medically complex patients	EOC payment models	Other ²	SIM Initiative-wide ³	Any VBP or APMs
Medicaid	242,031 (15.7%)	75,374 ¹ (4.9%)	—	—	1,542,563 (100%)	1,542,563 (100%)

Source: Tennessee Award Year 3, Report 4 progress report.

— = relevant data were not provided in data source; APM = alternative payment model; EOC = episode of care; LTSS = long-term services and supports; PCMH = patient-centered medical home; SIM = State Innovation Model; VBP = value-based payment.

¹ Although this represents 4.9% of the total Medicaid population, it is 54.9% of all TennCare members who are eligible for Health Link (137,394).

² “Other” represents LTSS.

³ All 1,542,563 Medicaid beneficiaries were eligible for an episode if they had a diagnosis or event that triggered an episode. Consequently, the state reports that 100% of the Medicaid population is reached by a VBP model.

Table J-3 reports the number of beneficiaries that had an episode in Award Year 2.

Note: The denominator for Medicaid (1,542,563) is all TennCare network members. The denominator for Statewide (6,715,984) is the total state population.

Table J-3. Payers participating in a value-based payment or alternative payment model in Tennessee, as of Award Year 2

Payer	Category 1 Payment: FFS with no link of payment to quality ¹		Category 2 Payment: Payment linked to quality		Category 3 Payment: APMs		Category 4 Payment: Population-based payment	
	Number of beneficiaries	Percentage of payments	Number of beneficiaries	Percentage of payments	Number of beneficiaries	Percentage of providers receiving payments ²	Number of beneficiaries	Percentage of payments
Medicaid	0 ¹	0%	—	—	22,090 (perinatal)	16.1%	—	—
					12,939 (acute asthma exacerbation)	3.0%		
					460 (total joint replacement)	12.9%		
					2,110 (cholecystectomy)	10.7%		
					2,929 (colonoscopy)	19.3%		
					4,116 (COPD)	11.7%		
					416 (PCI-A)	16.7%		
					128 (PCI-N)	24.2%		

Source: Tennessee Award Year 3, Report 4 progress report.

— = relevant data not provided in the data source; APM = alternative payment model; COPD = chronic obstructive pulmonary disease; EOC = episode of care; FFS = fee for service; LAN = Learning and Action Network; PCI-A = Percutaneous Coronary Intervention–Acute; PCI-N = Percutaneous Coronary Intervention–Non-acute.

¹ Tennessee’s Medicaid program is 100% managed care, with no FFS payments.

² Unlike other Model Test states that report the percentage of *payments* that are attributed to each LAN category, Tennessee reports the percentage of *providers* who received payments (gain-sharing) or penalties for each EOC.

Table J-4 presents the number of Tennessee’s providers participating in the SIM payment and health care delivery models. Because this table includes information submitted in Award Year 3, it does not include the 39 additional providers that implemented PCMHs or the one additional Health Link provider that implemented its programs in January 2018. As of Award Year 3, Tennessee reported 29 provider organizations participating in PCMH and 21 in Health Link. Both metrics were reported for the first time in Award Year 3.

Table J-4. Providers participating in a value-based payment or alternative payment model in Tennessee, as of Award Year 3 Annual Report

Provider type	SIM models				Landscape	
	PCMHs	Health homes for medically complex patients	EOC payment models	Other ¹	SIM Initiative-wide	Any VBP or APMs
Provider Organizations	29	21	—	—	—	—

Source: Tennessee Award Year 3, Report 4 progress report.

— = relevant data not provided in data source; APM = alternative payment model; EOC = episode of care; LTSS = long-term services and supports; PCMH = patient-centered medical home; SIM = State Innovation Model; VBP = value-based payment.

¹ “Other” refers to LTSS.

J.2.3 Enabling strategies to support health care delivery transformation

Key Results
<ul style="list-style-type: none"> • The state’s partnership with THA resulted in 83 percent of THA hospitals providing ADT data to the CCT, representing 66 percent of all hospitals in the state. • The CCT was well received and widely used by PCMHs and Health Link practices. • TA provided through TennCare and contractors, Navigant and Altruista, facilitated program implementation and alignment for PCMH and Health Link providers. • Tennessee leveraged its contracts with TennCare MCOs to achieve measure alignment across all three TennCare MCOs in its SIM program. • Implementation of the ERC QA resulted in NF providers receiving near-real-time feedback on performance measures and in a streamlined NF reporting process.

Tennessee’s SIM Initiative continued several key enabling strategies to support delivery system and payment reform. These included health information technology (health IT), TA, workforce development in TennCare’s LTSS direct care workforce, and quality measure alignment (**Table J-5**).

Table J-5. Tennessee’s progress on enabling strategies to support health care delivery transformation

Activity	Target population	Key activities	Progress between May 1, 2017, and March 31, 2018
Health IT and Data	PCMH and Health Link Providers	CCT	<ul style="list-style-type: none"> Two-thirds of hospitals submitted ADT data. CCT implementation helped identify and close health care gaps. The CCT was described by stakeholders as a “game changer” in its positive impact on coordinating care.
	NFs with ERC	QA	<ul style="list-style-type: none"> The QA was implemented for ERC reporting and feedback.
Assistance to Practices to Support their Transformation Activities	Providers and practices	Measure development and implementation Stakeholder meetings; TAGs Training and TA	<ul style="list-style-type: none"> Workforce development quality measures were created. Measure alignment across all three TennCare MCOs in SIM Initiative was achieved. Multiple in-person meetings were held to achieve buy-in from stakeholders for each EOC development wave. TennCare provided CCT and Health Link training, and Navigant PCMH and Health Link training. Payers, TennCare, and the THA provided EOC training. Eventa provided extensive ERC outreach and TA.
Workforce Development	LTSS direct service workers ¹	Education	<ul style="list-style-type: none"> Pre- and early-service training modules were developed. Negotiations took place with secondary and post-secondary academic institutions, to use state education funds to support DSP participation and offer college credits for learning module completion.

ADT = admission, discharge, and transfer; CCT = care coordination tool; DSP = direct service provider; EOC = episode of care; ERC = Enhanced Respiratory Care; health IT = health information technology; LTSS = long-term services and supports; MCO = managed care organization; NF = nursing facility; PCMH = patient-centered medical home; QA = quality application; SIM = State Innovation Model; TA = technical assistance; TAG = Technical Advisory Group; THA = Tennessee Hospital Association; VBP = value-based payment.

¹ Direct service workers include nursing facility aides, direct support professionals, personal and home care aides, and home health aides.

Health information technology

The CCT continued to be the primary health IT strategy in Tennessee’s SIM Initiative. With the goal of facilitating care coordination and reducing gaps in care, this tool gave PCMH and HealthLink providers access to encounter data from MCOs, real-time ADT data from THA hospitals, and attribution data from MCOs.

The state’s continuing partnership with THA allowed it to bring most hospitals’ ADT feeds into the CCT—with an earlier goal of 50 percent participation among THA members exceeded by the end of March 2018. Fully 83 percent of THA hospitals provided ADT data to the tool, representing 90 percent of THA hospital beds. This represents 66 percent of all hospitals and 70 percent of all beds in the state. Both THA and the state felt that THA’s established credibility and involvement was key to bringing hospitals on board. As one state official put it, “It’s only with our partnership with the THA that we have seen success.” The state and THA were in discussion with all nonparticipating hospitals and continued to aim for full participation.

“[Providers] can see a diabetic is supposed to have four foot exams a year, and if someone’s only had two, then there’s a gap in care there. It would highlight that, and show it in red. It also risk stratifies patients, showing who’s getting better and who’s getting worse, who needs more care, who hasn’t seen the doctor in a while, and it shows if they’re in the hospital and what they’re in for.”

—State official

The CCT was used by PCMH and Health Link providers and, as of January 1, 2018, by pharmacists participating in the pilot phase of a Medication Therapy Management program. Established under collaborative practice legislation, the Medication Therapy Management program allowed participating pharmacists to access the CCT to oversee drug interactions, medication prescribing, and drug compliance. All participating providers received training on the CCT from Altruista (the state’s data vendor), THA, and the state.

Stakeholders were unanimously enthusiastic about the CCT. One provider called the CCT “a game changer.” Providers gave examples in which a patient received care in another facility or had a gap in care that they became aware of through the CCT. One provider discussed learning through a CCT notification that a regular patient went to the emergency department for routine primary care needs. “How would they know otherwise?” this stakeholder asked. “It’s such an opportunity.” Some Health Link providers dispatched staff to the hospital to connect with hard-to-reach members, when the CCT showed these members had been admitted. Navigant gave providers training on the tool to help them become comfortable in using it. Moving forward, the state pursued options to bring additional data into the CCT (including more ADT feeds) and planned to resolve lingering data issues with the tool’s functionality and interface (including correcting inaccurate lists of attributed patients).

“I genuinely believe every provider wants their patient to get the right care. There’s so much good information here that they never had before ... it lets them know about gaps, that data is on the right track.”

—Provider

Technical assistance

Navigant continued to provide training and TA for PCMH and Health Link providers. Navigant worked closely with MCOs to deliver individually tailored CCT training and assistance with NCQA accreditation and on board the second round of PCMH and Health Link practices. Each new practice was assessed, and Navigant developed individualized practice TA plans. PCMHs and Health Link providers also received individual practice coaching and attended provider conferences, regional learning collaboratives, and Webinars. State officials expressed the hope that conferences and learning collaboratives provided an opportunity for providers to step back from their clinical practice: “The value of that is to create time for them to think and create processes so when they go home, or when they go back to the practice, they can work on [practice transformation].”

Payer representatives were primarily responsible for EOC training, although TennCare and THA also provided members a variety of trainings. Payers held Webinars to explain the overall EOC model and the performance reports, quarterly sit-downs for high-volume episodes, and ad hoc individual coaching. Providers performing below the acceptable threshold typically received intensive, one-on-one training from payer representatives. Because EOCs represented a marked shift for providers, actionable training was important. Explained one payer, “It’s a legitimate point to say, ‘I know I need to save money, but I couldn’t even tell you how I’d go about doing that.’ ... helpful recommendations for saving money that are specific to what each practice’s opportunities are would go a long way.” TennCare MCOs recently began hosting peer-to-peer learning opportunities, including focus groups featuring high-performing providers.

TennCare’s LTSS division was responsible for TA for LTSS providers, with support from Eventa and the MCOs. The state worked with LTSS providers to build capacity around evidence-based processes and move toward desired outcomes. For the ERC program, the MCOs contracted directly with Eventa to oversee the program and provide TA to participating facilities. Eventa’s three facility liaisons visited each of the 10 facilities every week to review clinical factors, conduct monthly member satisfaction surveys, suggest new approaches and technologies, and promote improved care, decreased utilization, and increased savings. Explained an Eventa staff member, “We’ve got eyes on every building, every patient that’s seen under that ERC program, every single week.” MCOs also provided LTSS training, including training on NF quality metrics.

Across the full range of SIM activities, TennCare provided training directly to practices and providers, including a full-day training in early 2018 for new PCMH practices, which focused on the CCT, and ongoing training on Health Link. The state noted that engaging all providers in transformation could be challenging, both “the ones who get it and jump in quickly, and the ones that never pay attention to this stuff.” Because some providers were resistant to change, the state intentionally reached out to all providers, explaining the practice transformation

efforts and gaining buy-in. Providers appreciated the state’s receptivity to feedback on how to make trainings more helpful. THA also provided trainings to their members on EOCs and the CCT, primarily at member request.

Quality measure alignment

Tennessee leveraged its contracts to achieve measure alignment for PCMH and Health Link across all three TennCare MCOs in the SIM program. Providers received reports on the same quality measures and the same thresholds across their entire Medicaid panel. Even with consistent comparison data, a provider might receive multiple reports from TennCare, making it difficult to digest and distill specific areas for improvement. The state used feedback consistently to make changes to the reports. One strategy was to ask MCOs to send raw data spreadsheets to the providers with their Portable Data Format (known as PDF) summary reports, so providers could conduct their own analyses. However, analyzing data was resource intensive, and not all practices had the requisite skills or time to do so.

Stakeholder feedback about the primary care measures was mixed. One MCO said the alignment between PCMH and Health Link metrics gave both types of providers a shared interest in getting Health Link enrollees to visit their PCPs and address care gaps. One payer said, “One of the strengths of the program is that quality metrics for PCMH and Health Link are the same. So, now not only does the PCP want to make sure their patient gets a wellness exam or chronic care management, but the Health Link provider is also incentivized to make sure this happens.” As one provider stakeholder said, “Being able to share this type of information to make sure that when they go to the primary care visit, they get the appropriate care. That’s been an early success that we can see.”

Some pediatric practices, however, said they had not found the PCMH measures the best indicators of good pediatric care and used a different set of 30 measures. One PCMH provider cross-walked its quality reporting requirements and identified 79 measures, including the PCMH and the Healthcare Effectiveness Data and Information Set. The same provider reported talking to the MCOs about additional alignment, saying they were receptive and working on the issue. An internal work group was formed to work on aligning 2018 quality goals for the PCMH, Health Link, and the MCOs, although whether changes to the measure slate were considered was not clear.

“Trying to come up with a collective set of consistent, well-understood, easily measured outcomes in the primary care side has been a lot harder than I would have initially intuited going into it.”

—State official

Workforce development

Tennessee continued to build workforce capacity among TennCare’s LTSS direct service providers (DSPs). Tennessee worked with secondary and post-secondary institutions to

develop a certification program for DSPs and minimize financial barriers for low-wage workers. To do this, the state selected a learning management system called Learning Objects, developed pre- and early-service training modules for the certificate program, and selected pilot sites. TennCare is negotiating with educational institutions to allow DSPs to use funds from Tennessee Promise (for recent high school graduates) and Tennessee Reconnect (for adult learners) to participate in the program and to receive college credits for completing learning modules. Both programs were statewide, free, community college education programs funded by the state’s lottery.

J.2.4 Population health

Key Results
<ul style="list-style-type: none"> • The DOH finalized a set of 12 Vital Signs and developed Vital Sign submeasures known as Key Health Signals, following several rounds of stakeholder feedback sessions. • The DOH developed QI logic models for all 12 of the Vital Signs in partnership with the National Academy of Medicine.

Tennessee’s population health activities included clinical approaches, innovative patient-centered care, and community-wide initiatives. The state’s EOC, PCMH, and LTSS payment reform strategies were considered transformative clinical care approaches (*Table J-6*). PCMHs, Health Link, and CCT were components of the state’s approaches to improve patient-centered care. The State Health Plan was the SIM Initiative’s community-wide population health strategy.

The State Health Plan, which the DOH developed and administered, made progress in its early phases of implementation. Several rounds of stakeholder forums collected input on measures to provide a meaningful scoreboard of Tennessee’s population health. In fourth quarter 2017, the DOH finalized a set of 12 Vital Signs. To allow more in-depth analyses, they developed submeasures for the Vital Signs, known as Key Health Signals. In partnership with the National Academy of Medicine, the DOH developed QI logic models for all 12 of the Vital Signs and was building an interactive Web database of Vital Sign QI resources (the Healthy Ideas Exchange). The DOH anticipated introducing Vital Signs to their internal staff in June 2018, so staff could prepare an external roll-out communications strategy.

In fourth quarter 2017, the DOH also began a final draft of the 2017 Update to the State Health Plan, to include a deep dive into how congregations and faith communities might apply the State Health Plan framework for improving community health. Additional funding would be required for local health departments to implement the projects envisioned, but the state did not report any action toward sustainability.

Table J-6. Tennessee’s progress on population health

Activity	Target population	Key activities	Progress between May 1, 2017, and March 31, 2018
State Health Plan	All Tennessee residents	State Health Plan development and updates Vital Signs Key Health Signals Vital Signs Implementation	<ul style="list-style-type: none"> Began work on the 2018 update to the State Health Plan. Held stakeholder forums to discuss Vital Signs measures. Finalized and published Vital Signs. Developed Key Health Signals based on stakeholder feedback. Finalized and published Key Health Signals. Developed Vital Signs QI logic models. Began building Healthy Ideas Exchange. Began planning for internal introduction of Vital Signs.
Clinical Approaches	TennCare members	EOC, PCMH, and LTSS	<ul style="list-style-type: none"> Continued implementation of the EOC, PCMH, and LTSS initiatives.

EOC = episode of care; LTSS = long-term services and supports; PCMH = patient-centered medical home; QI = quality improvement.

J.2.5 Sustainability

Key Results
<ul style="list-style-type: none"> Tennessee’s SIM Initiative was developed with sustainability in mind. EOC sustainability depends on long-term maintenance. Stakeholders are optimistic that they will be supported beyond the SIM Initiative.

Tennessee’s SIM Initiative was developed with sustainability in mind. The state used its SIM funding for design and not for supporting program implementation. Strategies were implemented by carriers whose activities are not SIM Initiative funded. The state’s contracts with carriers and MCOs included all the SIM Initiative strategies.

The sustainability of the EOC model depends upon long-term maintenance of the episodes. Legislative challenges and complexities around monitoring the high number of episodes are the biggest sustainability challenges. Nonetheless, most stakeholders were confident the EOC model would persist beyond the SIM cooperative agreement period, for the following reasons:

- The state’s contracts with carriers and MCOs included EOCs. The Benefits Administration included EOCs in its contract for state employees.
- Claims processing, programming, and report generation was all done by the MCOs (and their contractors), which was considered more sustainable than the state having these responsibilities.
- State officials and payers agreed to regularly review episodes and adjust or remove those with low volume, low value, or little practice variation. One state official said that once they finished rolling out episodes and “calm down and reach maintenance,” they would be able to work on partnering with providers and shifting the collective state mindset to this new way of paying for care.
- Payers expressed confidence, despite resistance, that episodes would continue to progress in the commercial market, albeit at “a significantly slower pace than on the Medicaid side.”

“Commonality between the programs is helpful when it makes sense. But if we take it to an extreme and say in Tennessee this is exactly how all payers should be handling every EOC, to me that’s not great. It’s good to have innovation and it’s good for us or our competitors to say we’re coming out with a different model ... you need some flexibility in innovation, especially for provider adoption when they can vote with their feet.”

—Payer

To succeed, all agreed that the EOC model could not be static. One state official described “growing and evaluating and making decisions as we move along the process, all of which will contribute to sustainability.”

J.3 Implications of Findings/Lessons Learned

The SIM Initiative achieved four major milestones during the AR3 analysis period:

- In January 2018, 39 PCMH practices and 1 Health Link practice joined the SIM Initiative, bringing the totals to 67 PCMHs and 22 Health Link practices.
- TennCare implemented 29 individual EOCs.
- EOC models touched most insured populations in the state, because the state collaborated with stakeholders and was flexible with design implementation, including maintaining voluntary provider participation and not implementing downside financial risk for state employee and commercial plans.

“This would never have happened originally without the SIM grant. We would have had in the marketplace three different ACO [accountable care organization]-like programs from each MCO. At some point in time, that model gives out. ... From a standpoint of provider engagement, the SIM grant has enabled one program, one model, one tool. As deliberate as this work is, it is the only way this could happen on this scale.”

—Payer

- The CCT was enthusiastically accepted by providers and promoted by the THA, providing an effective tool for coordination of patient care, with 66 percent of hospitals providing ADT information. The tool's use was enhanced by training provided by Navigant.

Based on the SIM implementation experience, stakeholders offered several opportunities, remaining challenges, and lessons learned for other states:

- Engaging commercial providers was challenging. Listening to stakeholder concerns, working collaboratively through them, and being flexible in model design and program implementation were needed to enlist their participation.
- Providers' tools enabling ready access to patient data or providing immediate feedback on quality measures had a profound, positive impact on coordinating care and improving quality. Training was critically important in helping providers maximize the tools' operability.
- Sustainability planning early in the SIM Initiative and laying out the management transition to payers and MCOs contractually aided in maintaining the SIM Initiative's momentum.
- Innovation, together with flexibility, made stakeholders feel as though they had a voice in planning and implementation, although balancing that flexibility with firm program boundaries was also important.

"The whole concept of providers being able to influence other things around them is foundational to all the models, and it continues to be met with criticism. ... We can work with you on all sorts of things that will make this better, improve information flow, make things fairer, etc., but here are lines in the sand that are foundation to what we do and can't be crossed."

—State official

Appendix K: State Innovation Model in Model Test States: Washington

Key Results from Washington's State Innovation Model Initiative May 2017–March 2018

Strategies, progress, and accomplishments, May 2017–March 2018

- Integration of physical and behavioral health in Medicaid managed care organizations (MCOs) expanded into the second of nine multicounty regions.
- Half of Washington's Federally Qualified Health Centers (FQHCs), but no rural health clinics (RHCs), moved to a per member per month (PMPM) payment model for their Medicaid patients.
- The Accountable Care Program (ACP) for public employees exceeded its enrollment goals and improved on nearly all quality measures.
- Accountable Community of Health (ACH) administrative organizations matured.

Stakeholder response to implemented strategies

- Behavioral health providers needed technical assistance (TA) in their move to contracting with Medicaid MCOs—most notably, in establishing new billing systems.
- Health Innovation Leadership Network (HILN) members agreed to take action in support of adopting alternative payment models (APMs).

Remaining challenges

- Expansion of value-based payment (VBP) adoption remains a challenge in the commercial and self-insured markets.
- The networks participating in the multi-payer data aggregation initiative were unable to use data from outside their own networks to manage patient care.
- The rural multi-payer model was delayed because of the need to redesign the model and to be responsive to the needs of a broader set of providers and stakeholders.

Sustainability after the SIM award

- The Health Care Authority (HCA) began to move ongoing administration of payment and delivery system reforms into regular agency operations.
- The state has enacted laws that support continuation of several of the payment and delivery system reforms.
- The Medicaid Transformation Project will provide continued support for ACHs and integration of physical and behavioral health.

Washington’s SIM Initiative began on February 1, 2015. SIM Initiative leaders are using the HCA’s purchasing power to move provider payments “from volume to value” to deliver whole-person care and improve community health through a regional approach. To accomplish its goals, the state is testing new payment models that are fostering behavioral and physical health integration through managed care; creating VBP options for FQHCs, RHCs, and rural critical access hospitals (CAHs); and offering an accountable care option to public employees. The state is also equipping providers with multi-payer data to facilitate adoption of VBP. The nine regional ACHs bring together local stakeholders from multiple sectors to ensure that the transformed delivery system meets local clinical and population health needs.

This updated overview of the Washington SIM Initiative is based on analysis of data collected from site visits, state document reviews, and state program and evaluation calls between May 1, 2017, and March 31, 2018.¹ Information on the number and types of stakeholders interviewed for the state is in *Table 1-1*. *Figure K-1* depicts the timeline of major Washington SIM Initiative and SIM-related activities through the end of the Annual Report 3 (AR3) analysis period, which began May 1, 2017, and ended March 31, 2018.

“To achieve the...health care innovation aim, Washington State as a purchaser will take a lead role as ‘first mover’ to accelerate market transformation. Washington will lead by example by changing how it purchases care and services in state purchased insurance programs.”
—State Health Care Innovation Plan

K.1 Key State Context and Progress Prior to May 2017

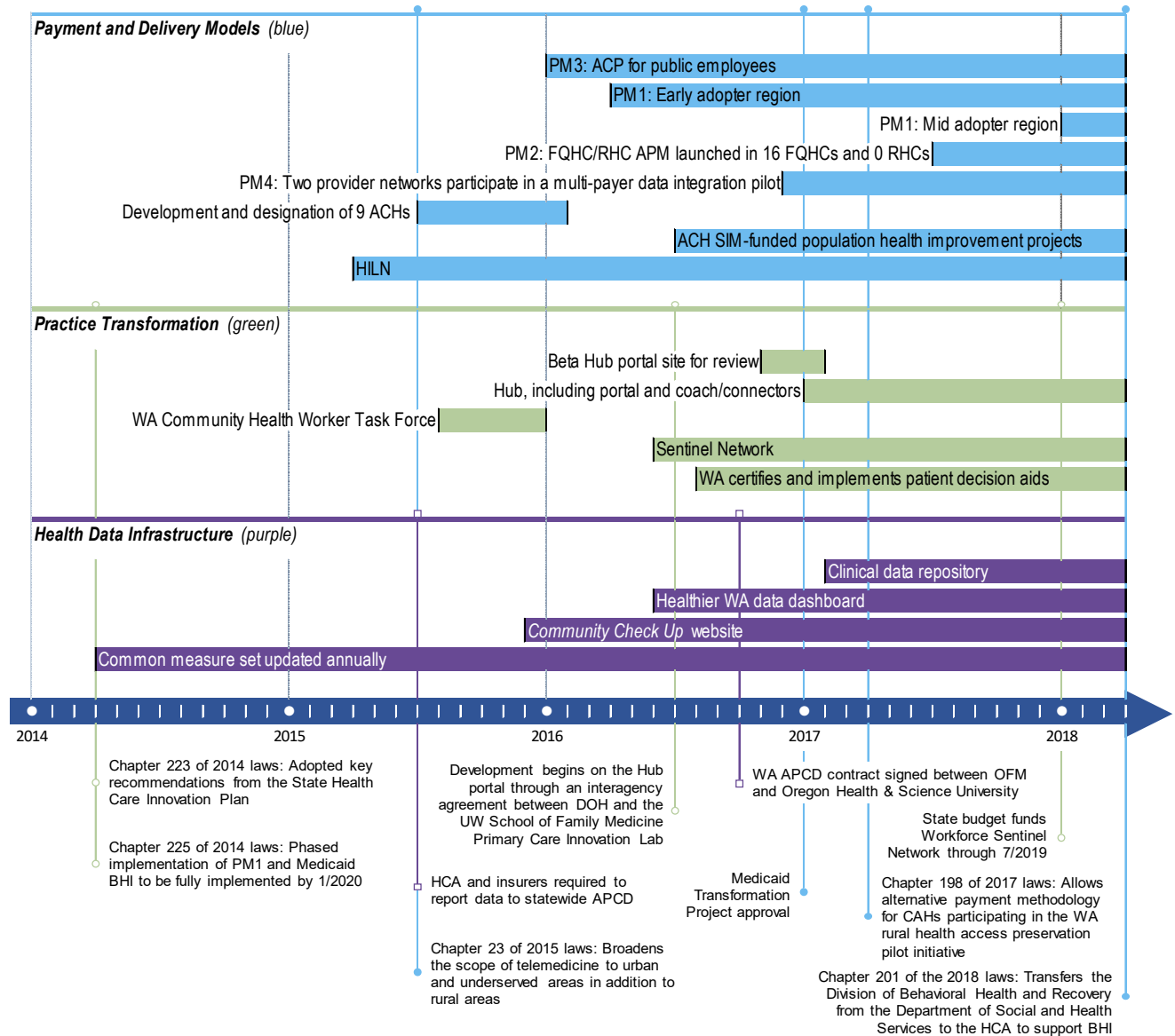
K.1.1 Pre-State Innovation Model health care in Washington

Since 1993, Washington’s HCA has combined the purchasing power of the Medicaid program with that of the Public Employee Benefits Board (PEBB), the state agency that purchases coverage for public employees and their families. Before receiving its SIM award, the state also had an established Medicaid managed care program, and most Medicaid beneficiaries were receiving physical health services through an MCO.

Prior to the SIM award, Washington had a voluntary all-payer claims database (APCD), an aligned outcome measure set and a source of evidence-based care recommendations. The state also participated in other federal initiatives, including 2,703 Health Home State Plan amendments, Transforming Clinical Practice Initiative awards, a CMS Partnership for Patients award with the Washington State Hospital Association, and CMMI Health Care Innovation Awards.

¹ Telephone interviews with stakeholders who could not be seen during the site visit and in-person focus groups were completed by April 12, 2018.

Figure K-1. Timeline of Washington State Innovation Model and State Innovation Model-related activities



ACH = Accountable Community of Health; ACP = Accountable Care Program; APCD = all-payer claims database; APM = alternative payment model; BHI = behavioral health integration; CAH = critical access hospital; DOH = Department of Health; FQHC = Federally Qualified Health Center; HCA = Health Care Authority; HILN = Health Innovations Leadership Network; Hub = Practice Transformation Support Hub; OFM = Office of Financial Management; PM = payment model; RHC=rural health clinic; Sentinel Network = Washington Health Workforce Sentinel Network; SIM = State Innovation Model; UW = University of Washington; WA = Washington.

K.1.2 State Innovation Model Initiative progress and changes prior to the Annual Report 3 analysis period

Washington implemented its SIM Initiative primarily through state legislation and purchasing power. For example, in 2014, the state passed a law that directed the HCA to increase value-based contracting and phase in fully integrated physical and behavioral health into Medicaid managed care. In 2016, the HCA issued its first *Value-Based Roadmap*, which detailed the state's strategies for using the purchasing levers of the HCA to achieve its goal of making 90 percent of all HCA payments to providers through VBP by 2021.²

In January 2017, CMS approved the Washington Medicaid agency's Section 1115 Delivery System Reform Incentive Payment waiver. This waiver, which is referred to as the Medicaid Transformation Project, provided support for further delivery system reforms, several of which built on those developed under the SIM Initiative.³

Prior to the AR3 analysis period, the Washington SIM Initiative had implemented almost all SIM payment and delivery system reforms but faced some challenges. All nine ACHs were operational and had launched SIM-supported health improvement projects. Practice transformation activities were underway, as was development of a mandatory APCD. However, implementation of the payment and delivery redesign originally targeting CAHs was delayed, partially because of ongoing discussions with Medicare about its participation in the proposed model, and partially due to ongoing and evolving stakeholder conversations. The HCA also began shifting the role of the HILN from advisory to action, asking HILN members to commit to specific actions that would advance VBP. The HCA strived to recruit and retain staff for its Analytics, Interoperability, and Measurement (AIM) team. Additionally, expansion of VBP innovations developed under the SIM Initiative in the commercial market was limited.

² HCA. (2018, January). *HCA Value-based Roadmap 2017–2021*. Retrieved from <https://www.hca.wa.gov/assets/program/vbp-roadmap-2017.pdf>

³ Washington's Medicaid Transformation Demonstration provides \$1.5 billion in federal funding for 5 years to test innovative models of service delivery. Washington will implement three initiatives under the Demonstration: system transformation through ACHs, new long-term services and supports, and foundational community support services. Source: HCA. (2017, October). *Ten things to know about the Medicaid Transformation Demonstration*. Retrieved April 15, 2017, from <https://www.hca.wa.gov/assets/program/10-things.pdf>

K.2 Progress and Accomplishments from Washington’s State Innovation Models Initiative, May 2017–March 2018

K.2.1 Delivery models and payment reforms

Key Results
<ul style="list-style-type: none">• Medicaid MCO financial and administrative integration of physical and behavioral health in the first region to adopt the model (Southwest Washington) showed signs of leading to clinical integration.• Medicaid MCO integration of physical and behavioral health expanded into a second multicounty region, and the HCA issued a request for proposals (RFP) for the remaining regions.• Sixteen of 32 FQHCs implemented the PMPM model and, together with the HCA, established performance measure reporting requirements.• The proposed CAH-only focused model was redesigned and expanded into a rural multi-payer volume-to-value model to include RHCs and other rural providers. Providers expressed excitement about the new model’s potential, as well as concern about whether the model could provide sufficient support for the most financially stressed hospitals.• The two PEBB Accountable Care Networks (ACNs) received their full share of savings by exceeding their service delivery goals and improving on nearly all quality measures. Enrollment in 2018 increased by 42 percent, with the ACNs retaining over 93 percent of their prior-year enrollees.• ACHs developed strong relationships across regions that included information sharing.

During the AR3 analysis period, Washington continued to expand the reach and enrollment in the four payment models implemented under the SIM Initiative. The four models are (1) integration of Medicaid physical and behavioral health benefits into ACH region-based MCOs, (2) development of a Medicaid VBP model for FQHCs and RHCs and a multi-payer payment model for CAHs and other rural providers, (3) an ACP option for PEBB members, and (4) delivery of multi-payer data to two pilot provider networks (for purposes of aggregation, to accelerate VBP arrangements). In addition, nine regional ACHs were established to promote delivery system reform responsiveness to local needs, including population health. *Table K-1* summarizes the state’s progress on delivery system and payment reforms.

Payment Model 1: Medicaid integration of physical and behavioral health

Washington implemented integrated Medicaid MCO contracts in a second region (North Central) and released an RFP to secure MCO participation in the remaining regions. The regionally based system was intended to respond to diverse local needs and circumstances. One stakeholder noted that the differences in the ease and speed of the transition within individual counties was related to local political and community relationships and existing patterns of care.

Table K-1. Washington’s progress on delivery system and payment reforms

Activity	Target population	Key activities	Progress between May 1, 2017, and March 31, 2018
PM1: Medicaid integration of physical and behavioral health	Medicaid MCO enrollees to be in an MCO with integrated physical and behavioral health services statewide by 1/1/20	Contracting with at least three MCOs in each of nine regions for financially integrated physical health and BH care	<ul style="list-style-type: none"> Implemented in second region (North Central) on 1/1/18. RFP for all remaining regions and third MCO in first region (which initially implemented in 2016) released 2/15/18.
PM2: Volume to value: FQHCs and RHCs	Medicaid MCO enrollees served by FQHCs and RHCs	Moving FQHC and RHCs that voluntarily agree from per visit payment to PMPM	<ul style="list-style-type: none"> 16 FQHCs signed the memorandum of understanding and began implementation on 7/1/17. The one RHC expected to join withdrew on 8/22/17.
PM2: Volume to value: Washington Rural Multi-Payer Demonstration	Residents of rural areas in which a pilot is implemented	Pilot payment methodology for primary care and hospital services, incorporating multiple payers, including Medicare	<ul style="list-style-type: none"> Discussions with Medicare were ongoing. Model modified to potentially include all rural providers. Planned to contract by 1/1/19.
PM3: ACP	PEBB members	Contracting with two health systems to create two ACN plan options at risk for quality of care and health outcomes in nine counties	<ul style="list-style-type: none"> Enrollment increased to >25,000 in January 2018.
PM4: Greater Washington Multi-Payer Initiative	Patients attributed to a participating provider network	Two provider networks receiving data from multiple payers to promote care coordination, quality, and risk sharing, with funding for TA and infrastructure	<ul style="list-style-type: none"> The HCA and provider networks worked to address data sharing and aggregation challenges. One ACN changed data aggregation vendors. The data were not yet being used to improve patient care.
ACH	Statewide	Contracting with one ACH entity in each of nine regions to promote public/private partnership to coordinate and support local delivery system reforms and population health improvement projects	<ul style="list-style-type: none"> ACHs continued SIM-funded projects and participated in peer learning. ACHs planned projects to support Medicaid Transformation. Demonstration were approved in February 2018.

ACH = Accountable Community of Health; ACN = Accountable Care Network; ACP = Accountable Care Program; BH = behavioral health; FQHC = Federally Qualified Health Center; HCA = Health Care Authority; MCO = managed care organization; PEBB = Public Employee Benefits Board; PM = payment model; PMPM = per member per month; RFP = request for proposals; RHC = rural health clinic; SIM = State Innovation Model; TA = technical assistance.

Based on the implementation experience in the first region to adopt the model (Southwest Washington), the HCA focused the TA for behavioral health providers in other regions on billing system development. Stakeholders reported gaining a greater appreciation for differences among behavioral health providers in their billing experience and sophistication. Many clinics had to shift from billing a single behavioral health organization (BHO) to billing multiple MCOs—with limited or no experience with individual claims submissions and, in some cases, lacking the needed information technology (IT) infrastructure. Substance use disorder treatment providers often faced greater difficulty than mental health providers in shifting to MCO billing.

Based on lessons learned through Southwest Washington’s implementation, which occurred in 2016, the Hub supplied behavioral health providers in the North Central region with both readiness assessments to identify gaps in providers’ systems capabilities and TA to fill those gaps. MCOs held provider trainings. Going forward, interviewees thought that ACHs could provide additional billing support.

Early indicators suggested that financial and administrative integration was leading to clinical integration. The state evaluation of PM1 found early indications of improvements on some health care delivery outcomes in Southwest Washington, including improved care coordination (e.g., follow-up for emergency room visits for alcohol or drug dependence).⁴ Some behavioral health provider focus group participants from Southwest Washington also reported that they were taking a bigger role in identifying physical health concerns, and one reported developing better relationships with primary care providers (PCPs). However, these focus group participants also expressed concern that this new responsibility reduced the amount of time they had to attend to the behavioral health needs of their patients. Interviewees expressed support for Washington’s approach of starting with financial and administrative integration. One payer said,

“... the integration of the financing and administration of physical and behavioral health ...acts as a facilitator to enable clinical integration, but it ... doesn’t magically make it happen.”
—MCO representative

“Had the state waited for a clinical integration formula to be set, we would still be debating whether behavioral health integration was the right thing to do. ... [W]here integration is being discussed, where these broad clinical formulas are established but where they don’t address the underpinning business model, the take-up is relatively low and the results are dismal. I think...without a business-enabling component to integration, it’s not sustainable.”

⁴ Mancuso, D. (2017, August 31). *Evaluation of fully integrated managed care in Southwest Washington: Preliminary first-year findings*. Retrieved from <https://www.hca.wa.gov/assets/program/FIMC-preliminary-first-year-findings.pdf>

Each region implemented behavioral health crisis and capacity building to address services the new MCO arrangements would not provide. During the AR3 analysis period, HCA teams helped counties with their transition planning to replace the county-level BHOs, which provided almost all behavioral health services, with regional Administrative Services Organizations that provide crisis-only services. Each region created a planning council to represent the multiple stakeholders in the local behavioral health system. One payer said, "... will the benefits gained from integration outweigh the loss of that single coordinating entity [the BHO]? I think so ... over time the system will adjust but we have to strategically adapt to the future."

Some stakeholders cautioned against moving forward too quickly with APMs for behavioral health providers. Although some clinics already used APMs—including case rates, cost-based reimbursement based on their operational budget, and subcapitation with risk—most were paid through fee-for-service (FFS) arrangements. One payer said that MCOs had not resolved how to attribute a population to a behavioral health provider, while a provider cautioned that savings based on behavioral health activities could be realized through changes in physical health spending, implying that the VBP system needed to take this into account when determining behavioral health provider payment under risk.

Washington changed the state agency structure to better support behavioral health integration (BHI). In March 2018, the governor signed legislation (Chapter 201 of the laws of 2018) transferring the Division of Behavioral Health and Recovery from the Department of Social and Health Services to the HCA. State officials anticipated that the transfer, effective July 2018, would provide the HCA with a division that understood the benefit package and the clinical populations with serious mental illness or addictions.

Payment Model 2: Medicaid per member per month payments to Federally Qualified Health Centers and rural health clinics

The PMPM payment model proved attractive to FQHCs, but RHCs believed the model would have less benefit for such clinics for two reasons. First, the RHCs lacked sufficient infrastructure and, second, the model applied only to Medicaid MCO enrollees, a smaller portion of the RHCs' than the FQHCs' patient population. On July 1, 2017, 16 of 32 FQHCs changed from encounter-based reimbursement to PMPM reimbursement for services provided to Medicaid MCO enrollees. Although the HCA had anticipated that one RHC would also make this shift, that RHC withdrew from the pilot soon after it launched, because the clinic was implementing a new electronic health record (EHR) system and did not have sufficient resources to simultaneously implement both the new EHR and the new payment model. The HCA planned to recruit additional FQHCs and RHCs—even though the agency recognized that the financial arrangement might not work for all clinics, especially those (e.g., many RHCs) that served primarily Medicare patients or did not have the necessary infrastructure in place.

FQHCs changed the way they delivered care in response to the quality measures incorporated into the PMPM payment model. The HCA and FQHCs worked together to develop a measurement reporting system, and in early 2018, they used the new system to produce baseline measures for each clinic. Measure production and validation required patients' PCP assignment information from MCOs, claims data from the HCA, and EHR data from clinics. FQHCs reported that participating clinics felt the development of the measure reporting system took too long but were pleased with the process that resulted. The FQHCs stated that HCA staff listened to their suggestions and were responsive to their needs. State officials reported being pleased with the system, observing that the clinics were starting to implement strategies to track and improve performance on the nine quality measures that factored into payment. Several FQHC provider focus group participants confirmed that they had noticed an increased focus on achieving quality metrics over the past year. To support sustainability of the model, Washington began to shift administrative responsibility for the reporting system to HCA ongoing operations.

"[The HCA] invited us to put together a task force, to provide ... feedback in a structured way. So, to their credit, they are working hard to make this as painless as possible"
—FQHC representative

Two stakeholders identified areas for improvement in the FQHC PMPM model. One payer felt the model did not allow enough flexibility for participating FQHCs to implement innovative patient care strategies, such as group clinic visits or telemedicine. One provider believed the model needed to better accommodate FQHC changes in scope of service, such as adding oral health.

Payment Model 2: Rural multi-payer model

The implementation of the PM2 rural multi-payer pilot was delayed, leading to stakeholder concern that sufficient time might not be remaining during the SIM award period to launch the new model. During the AR3 analysis period, the HCA, with input from CMS as well as state stakeholders, expanded the focus of its rural model to support all rural providers instead of just financially stressed CAHs, rebranding it as the rural multi-payer model. As of March 2018, the HCA had received 23 letters of interest representing approximately 47 organizations that wished to work with the HCA to develop this new model. The agency began meeting with potential payer and provider participants to further model development. The greatest challenge facing the rural multi-payer pilot was time, with limited time remaining in the SIM Initiative for the state to reach agreements with multiple providers, Medicare, and CMMI on model specifics.

Providers expressed excitement and concern about the model. Although providers generally said they were excited about the new model's potential, they also expressed frustration. Some had devoted significant time to development of the original model, and some worried that a model designed to help all rural providers might not sufficiently help the most critical and financially stressed hospitals. Still, these providers planned to participate in the ongoing

discussions, emphasizing the importance of developing a model that included both Medicare and Medicaid, because these two payers made up about 70 percent of the CAHs' payer mix. These providers welcomed the participation of commercial payers but believed it was most important to “get the system right” with their largest payers.

Payment Model 3: Accountable Care Program

The ACP produced cost savings and improvements in patient care. In October 2017, the HCA reported that the two ACNs for PEBB members—the University of Washington (UW) ACN and Puget Sound High Value Network, both contracted in 2016—outperformed their service delivery goals and improved on nearly all quality measures.⁵ State officials also reported that PEBB spent about one percent less than expected on ACN enrollees during the program's first year of operation. As a result, both ACNs received their full share of the savings they produced during the first contract year. One interviewee observed that the ACNs had implemented the strategies necessary for managing risk and improving performance on their 13 quality measures.

Public employees increasingly chose to enroll, and remain, in ACNs. During 2018 open enrollment, ACP enrollees increased by about 42 percent, and ACNs retained over 93 percent of their prior-year enrollees. Several interviewees cited the enrollment increases as one of the SIM Initiative's major successes to date. Two interviewees saw the high retention rate as an indication of enrollee satisfaction. Open enrollment activity brought the total number of PEBB members formally enrolled into the ACN program to more than 25,000 as of January 1, 2018, when open enrollment decisions became effective.⁶

State officials attributed this significant increase in ACN enrollment to two factors. First, enrollment was financially advantageous to many PEBB members. Premiums and deductibles were lower, with no cost-sharing for PCP visits. One ACN, for example, decreased its premiums by over 30 percent between 2017 and 2018. Second, state officials conducted extensive marketing of these two networks during the open enrollment period—targeting public employees with materials oriented to their anticipated health literacy level—and offering individualized assistance to human resources staff across state agencies. The HCA also considered, but ultimately discarded, other strategies to increase enrollment.⁷

⁵ HCA. (2017, October 18). *Preliminary results from accountable care organizations: Better care coordination, high interest among PEBB Program members*, News Release. Retrieved April 17, 2018, from <https://www.hca.wa.gov/about-hca/preliminary-results-accountable-care-organizations-better-care-coordination-high-interest>

⁶ The HCA estimated that as of January 15, 2018, approximately 30,000 additional public employees were receiving care from one of the ACNs but were not formally enrolled in the networks. The HCA also considered these attributed enrollees to be participating in the ACP and factored them into shared savings calculations.

⁷ For example, a strategy assigning employees to an ACN was discarded because (1) not all counties had ACNs, (2) this requirement might conflict with existing union contracts, and (3) assigning employees might appear punitive.

Payment Model 4: Greater Washington multi-payer initiative

Although the two contracted provider networks⁸ made progress in securing data from multiple payers, member providers were not yet using the data to improve patient care and manage financial risk. In December 2016, the HCA contracted with two provider networks—Northwest Physicians Network (urban) and Summit Pacific Medical Center (rural)—to implement this model to increase providers’ access to patient data across multiple payers. The HCA agreed to provide Medicaid and PEBB claims data, and TA and funding, for each network to develop a data aggregation system. Each network developed its own approach to data aggregation and securing the participation of other payers. As of March 2018, the networks had secured participation of other payers, and the HCA was sending Medicaid and PEBB claims data, but neither network was yet producing complete analytic data sets for its member providers from this data.

The provider networks and the HCA successfully resolved the technical challenges related to transmitting data but were still working to resolve those related to using the data. The vendor initially hired by both provider networks to aggregate claims data did not pass a complex security design review until mid-2017. Prior to transmitting data to the vendor, the HCA also had to upgrade its infrastructure, which presented multiple IT challenges. State officials reported the high level of encryption required to transmit Medicaid data, for example, as a huge barrier. Similarly challenging was identifying the individual beneficiaries to include in the dataset. The data transmitted from the state continued to present challenges to the network’s data aggregation vendor. One network reported that the PEBB data required notable amounts of data scrubbing. In addition, that network’s data-aggregation vendor was ill equipped to handle the full year of Medicaid claims data originally sent by the state, creating further delay because the state had to break the data transmission into twelve, 1-month segments.

In response to the data challenges, one network changed data vendors, and the other used in-house data to manage patient care. One network changed data vendors, because it believed the new vendor’s performance would be superior enough in the long run to counteract the delay initially caused by the vendor change. Another began using the Medicaid data already in house to populate its data platform, which enabled it to supply actionable information on those beneficiaries whose providers were at full risk contractually and for whom the network processed all claims and authorizations.

“[In the future] we can say here’s all five MCOs for the Medicaid book of business at your practice and here’s how you are performing on all of these pieces and not just the ones that we manage.”

—Network representative

⁸ Note that these provider networks are different from the ACNs described previously. The ACNs were developed by two health systems (UW and Puget Sound) to provide public employees with accountable care options. These two provider networks (Northwest Physicians Network and Summit Pacific Medical Center) are developing systems to receive and use data from multiple payers in care delivery.

Accountable Communities of Health

Many stakeholders commented that the ACHs had matured. Washington’s Medicaid Transformation Project, which runs from January 2017 through December 2021, offers the ACHs approximately \$1.1 billion to implement Medicaid delivery system transformation projects. With this additional support, the ACHs began to take on significant roles in Washington’s Medicaid transformation efforts. Many stakeholders found it difficult to distinguish between ACH SIM work and ACH work associated with the waiver, because of the overlaps in timing and the type of work involved. Stakeholders generally described the SIM Initiative as (1) providing foundational support for the ACH concept *and* helping ACHs build their capacity as entities and (2) facilitating the Medicaid Transformation Project’s larger scope of work.

ACHs developed strong relationships that supported information sharing across ACHs and were actively engaged in developing and leading peer learning activities.

According to one state official, the ACHs increasingly relied on one another and initiated peer learning calls. As their TA needs evolved, these calls focused on specific topics for different ACH staff roles (e.g., data, finance, health IT). The same state official explained that, in recognition of the work ACHs were required to do in preparation for the Medicaid Transformation Project, no new SIM projects were added to their portfolios over the AR3 analysis period. SIM resources were dedicated, instead, to support peer learning.

Tension between statewide standardization of ACH operations and allowing ACH flexibility to respond to local needs was ongoing during the AR3 analysis period.

Some interviewees commented that, in retrospect, it would have been helpful if the state had initially provided more standardized direction across ACHs. Requiring certain administrative and programmatic elements in the ACHs’ SIM projects would, according to this argument, have helped ensure that the projects addressed fundamental aspects of systems change that could demonstrate statewide impact. One interviewee characterized the issue as “whether you let 1,000 flowers bloom and see what happens” or instead provide specific direction and required focus. Going forward, Washington’s Medicaid Transformation Project established minimum standards for ACH governance and staffing capacity.

“... one of the biggest challenges is that there has been such a learning curve that the leadership of the ACHs have had to take on.”

—Payer

Sustainability

The HCA began to move the innovations tested under the SIM award into ongoing agency operations, but challenges to sustainability remained. The transition of the administration of the ACP and the new PMPM payment model for FQHCs into agency operations began during the AR3 analysis period. However, stakeholders were concerned that delays in implementing the rural multi-payer model might prevent that model from proving its value before the SIM award ends. In relation to the long-term success of the ACNs participating in the ACP,

one interviewee believed that increased enrollment and stronger restrictions on the use of out-of-network providers were needed.

State officials and the pilot multi-payer provider networks believed that their data aggregation efforts would be sustained in the future. State officials reported that, once the process was implemented, updates for Medicaid data would only require staff time. Because PEBB does not maintain its own claims data, however, it might be prohibitively expensive to get the data from a vendor. State officials were hopeful the networks would want to continue this work enough to eventually fund their data acquisition without SIM assistance. One network representative confirmed the network’s desire to continue.

With the end of SIM funding, ACHs will be supported by the Medicaid Transformation Project through 2021. Most stakeholders indicated that sustainability after the end of the Transformation Project would depend on ACHs demonstrating their value by accomplishing significant project tasks. One payer thought a key factor in ACH sustainability might be their ability to provide the structure and support necessary to form partnerships among providers and across sectors. This same individual commented that, because of improvements and changes in their communities and local health care systems, some ACH leaders believed their organizations would eventually be obsolete. To help continue transformation activities when SIM Initiative funding ended, the state planned to assist community partners seeking to work with ACHs, which could serve as a shorter-term sustainability strategy for the ACHs’ work. In the longer term, each ACH would need to find a permanent home within its local community or revenue stream within its local market.

K.2.2 Progress toward a preponderance of care in value-based payment and alternative payment models

Key Results
<ul style="list-style-type: none">• A state VBP survey of Medicaid MCOs, commercial insurers, and providers found that, in Calendar Year (CY) 2016, 28 percent of all state-financed payments were made through VBP, 39 percent of payments made by five of the major commercial payers were made through VBP, and 44 percent of Medicare Advantage payments were made through VBP.• The HCA aligned elements of VBP within and across Medicaid and PEBB, promoted alignment across payers, and advanced APM use in the commercial sector.• State officials believe that MCOs would adopt VBP more broadly if provided with appropriate TA.• Competition for qualified technical employees made the large technology companies reluctant to modify employee benefits, because strong labor market competition for high-tech workers made employee hiring and retention a continuing problem.• Limited resources and capacity heavily constrained RHCs’ and Indian health care providers’ ability to participate in VBP.

Washington’s goal is that, by 2021, “Ninety percent of state-financed health care and 50 percent of commercial health care will be in value-based payment arrangements (measured at the provider/practice level).”⁹ The state established an interim goal of 80 percent of state-financed health care by 2019 but expected to meet its 50 percent commercial payments goal by 2019. Washington defined VBP according to the categories in the Health Care Payment Learning and Action Network (LAN) framework¹⁰ and pursued models ranging from FFS payments with rewards for performance (LAN Category 2c) to comprehensive population-based payments linked to quality (LAN Category 4b).¹¹

Washington’s annual VBP survey found that VBP use increased between 2015 and 2016. Washington’s annual survey includes separate instruments for providers, Medicaid MCOs, and commercially licensed insurers. All five Medicaid MCOs, five commercial/Medicare Advantage payers, and 78 organizations representing a variety of provider types responded to the 2017 survey, which sought information on CY 2016 activity. Based on the payer responses, Washington found that in CY 2016, approximately 36 percent of payments for services were made through VBP (28 percent of state-financed payments, 39 percent of commercial payments, and 44 percent of Medicare-financed payments).¹² This value was an increase over the 30 percent the 2016 VBP survey found for CY 2015. One of the conditions of Medicaid MCOs receiving their one percent withhold was VBP survey participation.

Washington used its purchasing and convening levers to expand VBP use by the commercial market. For example, stakeholders reported that PEBB’s new third-party administrator contract requires that the ACNs, which place risk at the provider level, also be offered to the third-party administrator’s commercial book of business. Also, throughout 2017, the HCA worked with members of the HILN to develop an action agenda. HILN members made organizational commitments to actions they would take to spread VBP. Despite these efforts, state officials reported that expanding VBP use in the commercial market remained a challenge.

The HCA used its purchasing levers to spread VBP at the provider level in Medicaid and PEBB. The HCA ensured that its own contracts with health plans resulted in spreading APMs among providers. For example, in 2017, based on Medicaid Transformation Project requirements,

⁹ Needham, M., & Fischer, J. D. (2018, January 31). *HCA’s value-based roadmap and value-based purchasing survey results*. Retrieved from <https://www.hca.wa.gov/assets/program/VBP-Roadmap-and-VBP-Survey-Webinar-slides.pdf>

¹⁰The four LAN categories are (1) FFS with no link to quality and value, (2) FFS linked to quality and value, (3) APMs built on FFS architecture, and (4) population-based payment. Source: Alternative Payment Model Framework and Progress Tracking (APM FPT) Work Group, Health Care Payment LAN. (2016, January 12). *Alternative payment model (APM) framework: Final white paper*. Retrieved from <https://hcp-lan.org/workproducts/apm-whitepaper.pdf>

¹¹ HCA. (2018, January). *HCA Value-based Roadmap 2017–2021*. Retrieved from <https://www.hca.wa.gov/assets/program/vbp-roadmap-2017.pdf>

¹² Needham, M., & Fischer, J. D. (2018, January 31). *HCA’s value-based roadmap and value-based purchasing survey results* (p. 20). Retrieved from <https://www.hca.wa.gov/assets/program/VBP-Roadmap-and-VBP-Survey-Webinar-slides.pdf>

Medicaid began withholding a portion of its contracted MCOs' capitation payments. To earn this withhold, MCOs had to achieve established targets for VBP use at the provider level.¹³ Also, PEBB and Medicaid VBP contracts drew overlapping measures from the common measure set. State officials were confident these strategies would enable them to achieve the HCA's interim VBP goal of 80 percent in 2019, with one official expressing doubts about meeting the 90 percent goal by 2021.

Washington also sought to spread VBP models established outside the SIM Initiative. For example, the HCA's VBP roadmap explicitly established a strategy of expanding the bundles program. Additionally, the previously described MCO incentives for implementing VBP at the provider level were tied to each MCO's success in establishing any payment model that meets the LAN Category 2c criteria or higher. This could include both models developed under the SIM Initiative and those developed outside it and any models developed by commercial payers.

Table K-2 presents the extent to which Washington's Medicaid and public employee populations participated in the SIM payment and health care delivery models, as provided by the state in its fourth quarter Award Year 3 (AY3) progress report to CMMI.¹⁴ For the state's Medicaid population, Washington identified 176,400 individuals (9.0 percent) enrolled in an MCO with integrated physical and behavioral health services, an increase from 112,224 individuals (5.7 percent) reported for AY2.¹⁵ In addition, newly implemented in AY3, 308,611 Medicaid beneficiaries were attributed to an FQHC receiving funding through a PMPM payment model. This group represented 46.6 percent of all Medicaid beneficiaries attributed to an FQHC. In AY3, the state reported that 56,766 of the PEBB members living in a county offering an accountable care organization (ACO) were served by an ACN, an increase from the 47,102 reported for AY2.¹⁴ Finally, in AY3, the HCA implemented the Greater Washington Multi-Payer Model and reported that the model reached 2,381 Medicaid beneficiaries and public employees.¹⁶

¹³ HCA. (2017, November 8). *HCA value-based roadmap: Apple Health appendix* (p. 12). Retrieved from https://www.hca.wa.gov/assets/program/vbp_roadmapw-ah.pdf

¹⁴ These data values were not verified by CMMI. Thus, the RTI team cannot attest to their accuracy.

¹⁵ Population reached in AY2 are presented as they are reported in the AY3 Report 4 progress report. The numbers have been revised since they were initially reported in the AY2 Report 4 progress report.

¹⁶ According to the state, work is still underway to identify and define the population, providers, and provider organizations that PM4 will reach. At this stage in the development of PM4, no baseline numerator and denominator are available to report (Source: AY3, Report 4).

Table K-2. Populations reached by a value-based payment or alternative payment model in Washington, latest reported figures as of Award Year 3 Report 4

Payer type	SIM models			SIM Initiative-wide	Landscape Any VBP or APMs
	ACOs	BH integration	Other ^{1,2}		
Medicaid		176,400 (9.0%)	308,611 ¹ (46.6%)	— ³	—
Public employee plans	56,766 (28.2%)			56,766 (28.2%)	—

Source: Washington SIM Quarterly Progress Report for Award Year 3, Report 4.

— = relevant data not provided in the data source; ACO = accountable care organization; APM = alternative payment model; AY = Award Year; BH = behavioral health; FQHC = Federally Qualified Health Center; PMPM = per member per month; RHC = rural health clinic; SIM = State Innovation Model; VBP = value-based payment.

¹ Participation in the FQHC and RHC PMPM payment model.

² Participation in the Greater Washington Multi-Payer Model.

³ A SIM Initiative-wide total was submitted for AY2 but is not yet available for AY3.

Note: The denominators for Medicaid and public employee plans are provided by the state and include only those members targeted for inclusion and not the entire payer population. The denominator for statewide is the total state population and provided by United State Census American Community Survey 5-Year Estimates (<https://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml>); accessed on May 31, 2018).

Table K-3 presents the extent to which Washington’s payers participated in VBP or APMs as defined by the LAN categories.¹⁷ The state reports that as of AY2, 71 percent of Medicaid payments are in FFS. Among commercial payers, including state employee plans, 61 percent of payments are reported as FFS. The state reported data from fewer commercial and Medicaid payers in AY1 (baseline), and therefore, those numbers cannot be compared with the AY2 report.

Table K-3. Payers participating in a value-based payment or alternative payment model in Washington, latest reported figures as of Award Year 2

Payer	Category 1 Payment: FFS with no link of payment to quality		Category 2 Payment: Payment linked to quality		Category 3 Payment: APMs		Category 4 Payment: Population-based payment	
	Number of beneficiaries	Percentage of payments	Number of beneficiaries	Percentage of payments	Number of beneficiaries	Percentage of payments	Number of beneficiaries	Percentage of payments
Medicaid	469,563	71%	277,463	1%	213,748	20%	25,980	7%
Commercial	2,040,592	61%	41,040	13%	172,250	20%	272,072	6%

Source: Washington SIM Initiative Quarterly Progress Report for Award Year 3, Report 4.

APM = alternative payment model; FFS = fee for service; SIM = State Innovation Model.

¹⁷ The AY3 Report 4 progress report includes the following caveat for these AY2 data: “All data is from 9 self-reporting payers in Washington State. One of the five MCOs did not report covered lives and reported payments in Categories 3 and 4 combined. Plans reported covered lives by ‘Member Months,’ which we divided by 12 to arrive at these values.” The state did not report the methodology for dividing payments across Categories 3 and 4.

Table K-4 presents the number of Washington’s providers participating in the SIM health care delivery models as provided by the state in its fourth quarter AY3 progress report to CMMI. PEBB ACO networks included 10,214 (UW Medicine ACN) and 9,975 (Puget Sound High Value Network) physicians; 16 FQHCs participated in PMPM payment models; and 21 providers participated in the Greater Washington Multi-Payer Model.

Table K-4. Providers participating in a value-based payment or alternative payment model in Washington, latest reported figures as of Award Year 3 Report 4

Provider type	SIM models			Landscape	
	ACOs	BH integration	Other ^{1,2}	SIM Initiative-wide	Any VBP or APMs
Providers	10,214 ¹ (—%)	—	— ³	— ⁵	—
	9,975 ² (—%)		21 ⁴ (3.3%)		
Provider	8 ¹ (—%)	—	16 ³ (19.8%)	— ⁵	—
organizations	9 ² (—%)		2 ⁴ (100%)		

Source: Washington SIM Initiative Quarterly Progress Report for Award Year 3, Report 4.

— = relevant data not provided in the data source; ACN = Accountable Care Network; ACO = accountable care organization; APM = alternative payment model; AY = Award Year; BH = behavioral health; FQHC = Federally Qualified Health Center; PM = payment model; PMPM = per member per month; RHC = rural health clinic; SIM = State Innovation Model; UW = University of Washington; VBP = value-based payment.

¹ The total number of physicians or provider organizations participating in SIM PM3 (Uniform Medical Plan [UMP] Plus—UW Medicine ACN).

² The total number of physicians or provider organizations participating in SIM PM3 (Uniform Medical Plan [UMP] Plus—Puget Sound High Value Network).

³ Participation in the FQHC and RHC PMPM payment model.

⁴ Participation in the Greater Washington Multi-Payer Model. According to the state, work is still underway to identify and define the population, providers, and provider organizations that PM4 will reach. At this stage in the development of PM4, no baseline numerator and denominator are available to report.

⁵ A SIM Initiative-wide total was submitted for AY2 but is not yet available for AY3.

Note: The denominator for providers participating in BH integration is the total number of Washington billing providers participating in providing care to clients targeted for inclusion in Fully Integrated Managed Care. The denominator for provider organizations participating in BH integration is the total number of Washington billing provider organizations participating in providing care to clients targeted for inclusion in Fully Integrated Managed Care. For providers participating in ACOs, no denominators were provided. The denominator for provider organizations participating in the Other/FQHC and RHC PMPM payment model is the total number of billing providers providing care to beneficiaries receiving care from an FQHC or RHC. The denominator for providers participating in Other/Greater Washington Multi-Payer Model is the total number of providers targeted for inclusion in PM4 supported by the SIM Initiative.

Stakeholders reported that more support was needed to foster the spread of VBP, although there was no consensus about which stakeholders needed what support. Two state officials believed that the MCOs needed assistance to help them develop VBP contracts with providers. Payers, however, said that adoption of VBP by health plans was limited by providers' willingness and ability to enter into VBP contracts—that VBP adoption needed to “meet providers where they were” and then work with them to move them along the VBP continuum. A consumer advocate reported that behavioral health providers were willing to enter into VBP contracts but that health plans were not. Four stakeholders believed part of the solution to the VBP challenge was to develop a shared understanding among all stakeholder groups of the details of the VBP goals. Some reported stakeholder confusion about which payment models qualified as VBP and believed it would be beneficial to establish different goals for different types of providers.

Washington's employment market presented a challenge to spreading VBP. Competition for qualified technical employees in Washington's private employment market made large technology companies reluctant to modify employee benefits in a way that employees could perceive as restricting their access to care. In the public market, union contracts for state workers have prevented PEBB from (1) mandating public employees to enroll into ACN integrated care and (2) restricting employee access to only ACN-affiliated providers.

Neither RHCs nor Indian health care providers are participating in VBP due to payer mix and lack of provider resources. As previously mentioned, PM2 had been intended for both FQHCs and RHCs, but no RHCs participated in the model. State officials and providers both reported that RHCs chose to not participate because they did not view participation as financially beneficial. The fact that PM2 was only for Medicaid MCO enrollees—and many RHC patients are Medicare beneficiaries—limited the number of RHC patients for whom the RHC would receive PMPM payments. Furthermore, Indian health care providers and RHCs, which have very limited resources, were unable to build an infrastructure that would enable them to efficiently manage patient care that included many complex patients and financial risk. One interviewee believed that no tribal clinic had entered into a VBP contract with any payer, because all the clinics were too under-resourced to even consider doing so. State officials reported continuing efforts to encourage RHCs participation in PM2, and that these clinics also would be eligible to participate in the rural multi-payer model under development.

K.2.3 Enabling strategies to support health care delivery transformation

Key Results

- Washington continued to improve its AIM data system, and although staff turnover was a challenge, AIM supported the payment and delivery system reforms.
- The Washington All-Payer Claims Database (WA-APCD) was in place with data available to enhance the analytic capability of a broad range of stakeholders.
- The Hub was successfully implemented and actively engaged providers.
- A workforce development survey revealed a need for registered nurses and medical assistants and that rural employers faced recruitment challenges for multiple positions.

As part of the SIM initiative, Washington is testing several strategies to support the payment and delivery system transformations, including improvements in data analytics and data sharing, assistance to practices to support transformation activities, workforce shortage monitoring, and shared decision making (*Table K-5*). The state encountered and addressed foundational challenges during the AR3 analysis period that involved data analytics staffing, providing datasets to provider networks, and assistance to behavioral health providers in billing MCOs. The state also took steps to coordinate the SIM- and Medicaid Transformation Project-funded investments in enabling strategies. For example, Healthier Washington developed both a *Health IT Strategic Roadmap*¹⁸ and an *Operational Plan*¹⁹ to guide and coordinate the health IT investments made under each of the two funding sources.

¹⁸ HCA. (2017, September 26). *Medicaid Transformation Demonstration Project Health Information Technology Strategic Roadmap*. Retrieved May 7, 2018, from <https://www.hca.wa.gov/assets/program/health-information-technology-strategic-roadmap.pdf>

¹⁹ HCA. (n.d.). *Health IT Operational Plan 2017 to 2018*. Retrieved May 7, 2018, from <https://www.hca.wa.gov/assets/program/ay4-operational-plan-appx4.xlsx>

Table K-5. Washington’s progress on enabling strategies to support health care delivery transformation

Activity	Target population	Key activities	Progress between May 1, 2017, and March 31, 2018
AIM strategy	ACHs, local health jurisdictions, providers participating in PM2 and PM4	Improving data analytics and data sharing to assist practices in their transformation activities; Healthier Washington data dashboards for ACH regions	<ul style="list-style-type: none"> • AIM infrastructure was enhanced. • Developed a <i>Health IT Strategic Roadmap</i> and an <i>Operational Plan</i>.
WA-APCD	All providers and payers	Data sharing through Washington HealthCareCompare	<ul style="list-style-type: none"> • WA-APCD was implemented. • Received 4 years (2013–2016) of medical, dental, and pharmacy claims data covering the entire Medicaid population, almost all the Medicare Advantage market, and more than half of all commercial enrollees.
The Hub	Primary care and BH practices	Providing practices seeking to transform care delivery with coaching and other learning opportunities, a Web-based resource center, and connections to other support services	<ul style="list-style-type: none"> • Enrolled more than 150 practices in coaching services. • Developed a BH agency IT toolkit. • Offered the Value-Based Payment Practice Transformation Academy learning series.
Sentinel Network	Health workforce	Identifying major emerging workforce training and education needs	<ul style="list-style-type: none"> • Published reports on findings in July and August 2017.
Common measure set	All payers and providers	Developing a set of performance and quality outcomes measures that can be used across payers and providers	<ul style="list-style-type: none"> • HCA operationalized use of common measure set in VBP agreements for SIM payment models.
Shared Decision Making	All patients with certain conditions and their providers	Certifying and disseminating decision aids	<ul style="list-style-type: none"> • The state certified maternity and joint/spine patient decision aids. • ACNs incorporated these aids into clinical practice, as required by their contracts with the HCA.

ACH = Accountable Community of Health; ACN = Accountable Care Network; AIM = Analytics, Interoperability, and Measurement; BH = behavioral health; HCA = Health Care Authority; health IT = health information technology; Hub = Practice Transformation Support Hub; IT = information technology; PM = payment model; Sentinel Network = Washington Health Workforce Sentinel Network; SIM = State Innovation Model; VBP = value-based payment; WA-APCD = Washington All-Payer Claims Database.

Analytics, Interoperability, and Measurement strategy

Stakeholders reported that AIM staff turnover was a major issue. Several stakeholders reported that Olympia’s proximity to Seattle’s big technology companies made it difficult for state agencies to retain IT talent. AIM—a strategy of bringing together data from state agencies, payers, and providers and applying analytic tools, interoperable systems, and standardized measurement—was particularly hit by the resulting staffing shortages. Several noted the departure of the AIM team’s director as the biggest loss for Washington’s health IT efforts, although state officials said the loss was mitigated by the new director having previously been an AIM team member. One state official noted that the leadership transition was used as an opportunity to reassess health IT strategic direction.


Washington All-Payer Claims Database

The WA-APCD²⁰ was able to receive and process data for services delivered to most Medicaid, Medicare, and commercially insured people. In June 2017, the WA-APCD received 4 years (2013–2016) of claims data from health plans that provide comprehensive coverage. The data included medical, dental, and pharmacy claims covering the entire Medicaid population, along with almost all the Medicare Advantage market and more than half of all commercial enrollees.²¹ Washington plans to add data from specialty insurers (e.g., dental-only coverage) and self-funded, employer-sponsored plans to the WA-APCD later. One interviewee, however, expressed doubt that the state ultimately would be able to secure data from self-funded plans, because, by federal Employee Retirement Income Security Act law, states cannot require these entities to provide data.

Washington intends for the WA-APCD to offer flexible online access to stakeholders wishing to examine provider performance on the measures included in the common measure set, beginning in summer 2018. As of April 2018, there were 66 measures in the common measure set, with newly added measures on antidepressant medication management and opioid treatment. The WA-APCD opened a 30-day review and reconsideration period in March 2018 for PCPs, hospitals, and ambulatory surgery centers to review and comment on their scores and patient attributions. Public reporting, via the *Washington HealthCareCompare* Web site, was anticipated to begin in summer 2018.

Stakeholders anticipated that the existence of two APCDs—with two public sources of information on plan and provider performance, based on different data—might cause

²⁰ The WA-APCD was established by Washington’s Office of Financial Management, as directed by state legislation. In July 2016, this office selected the Center for Health Systems Effectiveness at Oregon Health & Science University as the lead agency for this effort. The Center for Health Systems Effectiveness partners with both a data vendor (Onpoint Health Data) and communications vendor (Forum One).

²¹ WA-APCD. (2017, June 29). *New WA-APCD welcomes data on 4 million Washingtonians*. Retrieved May 7, 2018, from <http://www.ohsu.edu/xd/research/centers-institutes/center-for-health-systems-effectiveness/wa-apcd-governance-information/upload/20170627-WA-APCD-Stakeholder-Update.docx> 

confusion. Washington’s use of *Washington HealthCareCompare* fills a role previously played only by the Washington Health Alliance’s *Community Check Up*. The Washington Health Alliance plans to continue publishing *Community Check Up*, as it has since 2015. *Community Check Up* is based on the data contained in the Alliance’s voluntary APCD, including provider and plan performance on the measures in the common measure set, based on data collected voluntarily from MCOs, health plans, and self-funded employers. The performance data reflected in the two data sources would likely differ, because each database contains data from an overlapping, but not identical, group of payers. Recognizing this potential confusion, state officials planned to make clear to data users the differences between the two datasets.

Common measure set

The HCA added measures addressing critical and emerging issues to the common measure set. In December 2017, the Performance Measures Coordinating Committee recommended the addition of measures of prenatal care, substance use, obesity, opioid prescribing, and patient experience with care coordination.²² In March 2018, after analysis, the HCA integrated the proposed measures into the common measure set.

The HCA promoted the common measure set as a starting point for alignment across purchasers. The HCA’s new value-based roadmap promoted use of these measures in VBP by purchasers. The HCA viewed the set as a promising starting point for purchasers, because stakeholders participated in the measure selection process, and publicly reported data were available for benchmarking. One advocate reported that some purchasers were already using these measures in contracts.

“With measure alignment, the physicians no longer have to worry about the type of coverage the patient has Now, the physicians open their dashboard daily with their team and determine which areas to improve and which patients need to be contacted.”

—Stakeholder

Stakeholders were generally positive about the common measure set, but some pointed to its weaknesses in certain areas. Most stakeholders were positive about both the process used to develop the common measure set and its use with VBP, but three drawbacks were noted: It included only clinical measures (i.e., nothing on social determinants of health), it had limited behavioral health and patient experience measures, and the included measures did not completely align with federal measure sets such as the Merit-Based Incentive Payment System.

²² HCA. (2017, December 18). *WA State Performance Measures Coordinating Committee (PMCC): December 18, 2017, 2:00–4:00 pm Meeting Summary*. Retrieved from <https://www.hca.wa.gov/assets/program/pmcc-meeting-summary121817.pdf>; and HCA. (2018, March 30). *WA State Performance Measures Coordinating Committee (PMCC): March 30, 2018, 2:30–4:30 pm Meeting Summary*. Retrieved from <https://www.hca.wa.gov/assets/PMCC-meeting-summary-3-30.pdf>

Practice Transformation Support Hub

The Hub helped providers understand and transition to the payment models implemented under the SIM Initiative.

Several interviewees identified the Hub-related activities to support providers as major accomplishments. The Hub successfully managed the early stages of its implementation and actively engaged providers.

Stakeholders noted growing recognition of the shift to VBP among providers and that more providers were seeking assistance about transitioning to these models. Interviewees also commented that the Hub helped providers gain a better understanding of how the different payment models within the SIM Initiative and health IT could directly support practice transformation efforts. In AY3, the Hub finished hiring coach/connectors for each ACH region and enrolled more than 150 practices in coaching services. From February 1, 2017, to October 23, 2017, more than 4,500 users visited the Hub's resource portal. On October 31, 2017, the portal launched a new feature allowing practices to customize portal resources.

"A year ago, we didn't know if we could get people engaged, but now we don't have enough resources to respond to the demand."

—State agency official

Unlike providers, some ACHs were less engaged with the Hub. Because of the delayed Hub startup, some ACHs sought alternative support resources. One interviewee noted that some ACHs preferred greater local control and felt that having a state agency manage a practice transformation resource for local providers was not the best approach.

Practice coaching focused primarily on physical health integration and BHI. To help ensure a smooth transition to managed care, the North Central region (the second region to adopt PM1) worked with the Hub to assess behavioral health agency EHR capacity. This resulted in development of a behavioral health agency IT toolkit. In response to behavioral health providers' lack of familiarity with different types of practice transformation initiatives and VBP models, the Hub partnered with the Washington Council on Behavioral Health and the National Council for Behavioral Health to offer the Value-Based Payment Practice Transformation Academy, a learning series designed to help selected behavioral health entities navigate issues related to VBP arrangements. Phase 1 of the Academy operated from October 2017 to January 2018; Phase 2 started in February 2018, with plans to run until August 2018.

Washington Health Workforce Sentinel Network

The Sentinel Network identified key health workforce shortages. The Sentinel Network gathered data on workforce trends to identify areas where there were deficiencies in training and education in relation to human resource needs and published reports on its findings in July and August 2017. The Network's survey found shortages in registered nurses and medical assistants and that rural employers faced challenges in recruiting for multiple positions. Sentinel Network activities have not been funded by SIM since AY1; however, recognizing the importance of

understanding workforce shortages, Washington has continued to support the Sentinel Network with non-SIM funding.

Shared decision making

Washington advanced patient decision aids, an innovative evidence-based initiative, through the state's ACNs. Patient decision aids embody a process where patients and providers make health decisions together, based on a combination of evidence and patient preference. During the AR3 analysis period, the state certified maternity and joint/spine patient decision aids, the ACNs started incorporating the certified aids into clinical practices, and more than 300 clinical providers received training on decision aids' importance and use.

Sustainability

Washington continued to improve and planned to sustain its AIM strategy. One major AIM online tool launched in 2016 was interactive data dashboards for ACHs and local health jurisdictions to leverage for planning, using Medicaid claims and enrollment data and immunization registry data to present performance on 19 measures by a wide variety of geographic and demographic characteristics. Five additional versions of the dashboards have been released, most recently in early 2018. Each release brought enhanced capabilities to users. Washington plans to sustain AIM through ongoing agency operations. AIM's anticipated future activities include updated data dashboards and improvements in Washington's cross-agency analytic capability to be responsive to other data needs of partners and stakeholders.

The HCA included reporting and performance requirements from the common measure set, developed under the SIM Initiative, in APMs that will continue post-SIM. The HCA worked with the FQHCs participating in PM2 to create a reporting system to capture their performance on eight of these measures. Medicaid MCOs were already reporting performance on these (and other) measures. Requiring reporting and achievement of common measure set outcomes across sustained initiatives underlined the importance of maintaining and updating the measures going forward.

Resources were not expected to be available to maintain the Hub beyond the end of the SIM award. Practice coaching most likely would not be continued after the SIM Initiative's end; the DOH planned to replace that initiative by connecting practices to other sources of TA or funding. The portal would likely be sustained, because key state agencies (i.e., the DOH, HCA, and Department of Social and Health Services) had an interest in its continuation.

The Sentinel Network and shared decision-making initiatives already were financed through agency operational budgets in the AR3 analysis period. Operational budget funding was instituted to protect both initiatives from being adversely affected by the loss of SIM Initiative funding.

K.2.4 Population health

Key Results
<ul style="list-style-type: none"> • The ACH’s fostered cross-sector collaboration to improve population health at the local level, but their original emphasis on implementing health improvement activities for the broader community shifted to implementing more clinically focused projects targeting the Medicaid population. • ACHs used data dashboards to produce regional health assessments and set priorities. • Improvements to population health were likely to continue at a slower pace and be smaller in scope than initially envisioned.

Washington’s SIM Initiative population health efforts included a central role for the nine ACHs, as overseen by the HCA, by bringing together a diverse group of community stakeholders to implement health improvement projects (*Table K-6*). The Plan for Improving Population Health (P4IPH), the state’s strategic plan for population health priorities, provided a structured set of health improvement strategies that communities could tailor to address the unique aspects of their local health needs. The DOH was chosen to lead the state’s population health initiatives, including implementation work associated with the P4IPH and Hub oversight.

Table K-6. Washington’s progress on population health

Activity	Target population	Key activities	Progress between May 1, 2017, and March 31, 2018
ACHs	Statewide	Implementing health improvement projects through local-level, cross-sector collaboration	<ul style="list-style-type: none"> • Increased emphasis on clinical-focused and certain mandatory projects targeting the Medicaid population may impede general population health activities. • ACHs used state data to formalize regional health assessments and set priorities. • Information sharing and peer learning increased across ACHs.
P4IPH	Statewide	Addressing BH and chronic disease prevention and management	<ul style="list-style-type: none"> • Diabetes prevention and treatment was selected as the primary focus area; well-child visits was chosen as the secondary focus area.

ACH = Accountable Community of Health; BH = behavioral health; P4IPH = Plan for Improving Population Health.

Accountable Communities of Health

Many interviewees reported that ACHs fostered local-level, cross-sector collaboration to improve population health. Across ACHs, SIM-related population health improvement projects ranged in topic and scope but had the consistent theme of increasing access to services. The areas of focus included behavioral health coordination for youth, chronic disease prevention and management, and community-based approaches to addressing opioid abuse. One state official commented that, although the ACHs had not unfolded as initially envisioned, they were

performing as the state expected. Although concrete outcomes were not yet evident, many interviewees considered that the ACHs' positive progress in fostering local-level, cross-sector collaboration addressed issues that affect population health, such as the opioid epidemic, in ways that would not have occurred otherwise.

Implementation of the Medicaid Transformation Project caused ACHs to temporarily narrow their population health focus to improving the health of the Medicaid population.

Interviewees noted that the ACHs' significant role in the Medicaid Transformation Project forced the ACHs to shift from the SIM Initiative's original emphasis on health improvement activities for the broader community to developing plans to implement projects targeted to the Medicaid population that are generally more clinically focused and meet their goals for their Medicaid Transformation Projects. Although interviewees still expressed a general sense that ACHs had the potential to improve population health in their communities, they anticipated that competing demands would lead to changes occurring at a slower pace and be smaller in scope than initially envisioned.

Data dashboards helped ACHs conduct community health assessments. During the AR3 analysis period, as noted, the ACHs used state data to formalize their regional health assessments and priorities, with the state developing scorecards and providing other community-level information for use at the provider and ACH levels. Additional data dashboards were developed to help providers assess their own performance on key metrics. One stakeholder described the ACHs as facing challenges in using the range of data they received from different sources to develop a cohesive, baseline picture of performance in their regions.

Plan for improving population health

Two primary foci were chosen for the state's population health efforts. In AY3, through further assessment activities, diabetes prevention and treatment was selected as the primary focus and well-child visits as the secondary focus for efforts to incorporate prevention into health system transformation efforts.

P4IPH activities were already sustained through agency operational budgets. The P4IPH did not receive SIM funding in AY3, with some state officials saying that the P4IPH had become part of the state's public health reaccreditation work, that it would continue to serve as a tool for the ACHs, and that it had the potential to be a platform to create clinic-community linkages for wellness promotion.

K.3 Implications of Findings/Lessons Learned

The SIM Initiative achieved the following major objectives during the AR3 analysis period:

- The HCA’s annual VBP survey, conducted in 2017, found that in 2016, payers had made about 36 percent of payments through VBP—an increase over the 30 percent of payments in 2015.
- The HCA expanded Medicaid MCO integration of physical and behavioral health into the second of nine multicounty regions and released an RFP to secure contractors in all remaining regions.
- Half of all FQHCs chose to move to a PMPM payment model with incentives for achieving quality metrics and worked with the HCA to implement a system for producing and reporting the metrics.
- More PEBB members joined an ACN, and both ACNs performed well enough on quality metrics to earn their full share of the savings they produced during the first contract year.
- The WA-APCD received and processed data for services delivered to most Medicaid, Medicare, and commercially insured people between 2013 and 2016.
- The Hub provided coaching to more than 150 practices and launched a learning series to help selected behavioral health entities navigate issues related to VBP arrangements.

Based on the SIM implementation experience, stakeholders identified promising practices, remaining challenges, and lessons learned that could be useful for other states pursuing system transformation. These include the following:

- Purchasing levers were effective in increasing the use of VBP by the plans and providers delivering services to Medicaid beneficiaries and public employees.
- Financial and administrative integration of physical and behavioral health services fostered clinical integration, and there were signs of increased clinical integration, including improvements on indicators of care coordination in the region that had implemented the integrated managed care model in 2016.
- Behavioral health providers needed support to move into integrated managed care.
- Providers participating in PM3 and FQHCs participating in PM2 were developing strategies to improve performance on the metrics incorporated into the two payment models.
- The provider networks participating in PM4 were not yet able to produce actionable reports from Medicaid and PEBB claims data because of technical challenges.
- No RHC elected to move from its current per-visit payment model to a PMPM payment model, primarily because RHCs lacked the resources and infrastructure needed to succeed under the model.

- Delaying development of a rural multi-payer model was necessary to pursue Medicare participation but could endanger the success of the model, because it may not be able to launch before the end of the SIM award.
- The expanded focus provided by the Medicaid Transformation Project challenged the ACHs to mature quickly and led them to change from implementing broad population health improvement projects to implementing projects that only covered the Medicaid population.

Appendix L: Qualitative Data Collection & Analysis Methods

This appendix provides detailed descriptions of the methods used to collect the 2018 site visit data by data type (*Sections L.1 and L.2*), followed by the methods used to analyze those data (*Section L.3*).

L.1 Stakeholder Interviews

During 2018, state evaluation teams conducted 202 interviews with key SIM Initiative stakeholders, including state officials, payers, providers, and consumer advocates. Each state suggested a pool of interview candidates for that state, which evaluation team members supplemented after their review of SIM-related documents. State evaluation teams selected the final list of interview candidates from this combined list, based on the nature of the respective stakeholders' involvement in the SIM Initiative. To encourage candid discussion and protect participants' privacy, the state evaluation teams withheld the final lists of interviewees from the state and CMMI. The state evaluation teams also assured participants that the evaluation reports would not attribute comments to individuals or their organizations.

To facilitate cross-stakeholder and cross-state comparisons, the evaluation teams developed standard interview questions for each stakeholder group. As *Table L-1* shows, participants from all groups discussed stakeholder engagement, delivery transformation, and payment reform. Fewer groups commented about the remaining topics listed in *Table L-1* because the issues were less relevant to their experiences. Within topics, each state evaluation team further tailored the protocols to leverage the knowledge and experience unique to the specific interviewee.

To ensure consistency across state teams, evaluation leaders trained the interviewers and note takers before the site visits to clarify roles, advise about interviewing practices, and review note-taking conventions. Pairs of state evaluation team staff—one interviewer and one designated note taker—conducted the stakeholder interviews. The interview leaders used the previously mentioned semi-structured protocols to guide each interview session, while note takers documented participants' responses.

Most interviews focused on the experiences of a single stakeholder, though multiple stakeholders participated in interviews that addressed scheduling constraints. Interviews typically lasted no longer than 1 hour and occurred at the interviewees' workplaces. When stakeholders were unavailable to interview in person and/or at the time of the site visit, interviewers conducted the interview via telephone, either before or after the site visit.

Table L-1. Major interview topic areas, by stakeholder type

Topic areas	State officials	Payers	Providers	Consumer advocates
About the respondent*	✓	✓	✓	✓
Overall implementation progress	✓	✓	—	—
Stakeholder engagement	✓	✓	✓	✓
Delivery reform	✓	✓	✓	✓
Payment reform	✓	✓	✓	✓
Health IT	—	—	✓	—
Quality measurement and reporting	—	—	✓	—
Preponderance of care	✓	✓	✓	—
Population health	✓	—	—	—
Sustainability	—	✓	✓	—

*New participants only; ✓ = interview topic included in the cross-state interview protocol; — = interview topic not included in the cross-state interview protocol; health IT = health information technology.

With participants’ consent, state evaluation teams audio recorded the interviews so the note takers could refine their notes after the site visits. Team members stored all notes and recordings on secured servers.

L.2 Focus Groups

State evaluation teams conducted 39 focus groups with consumers and providers to obtain their perceptions of, and experiences with, SIM Initiative reforms. State evaluation teams developed screening criteria for each focus group to recruit the providers and consumers most likely to be affected by each state’s SIM Initiative. Across states,

- providers were required to be licensed, to have practiced medicine for at least 1 year, and to accept Medicaid; and
- patients were required to be adults aged 18–64 years, to have received care within the past 6–12 months, and to have the ability to converse in English.

State evaluation teams identified one or two locations for the focus groups in each of the 11 Model Test states. The locations were selected to ensure sufficient concentrations of the targeted populations from which to recruit participants. Individuals living outside the targeted communities were excluded from participating in the focus groups.

Once the state evaluation teams identified the target focus group populations and locations, they worked with the states to acquire lists of names and contact information for eligible participants. To ensure focus groups of sufficient size, for every 12 desired focus group participants, the teams typically requested a recruitment list of at least 100 individuals.

Table L-2 shows the detailed inclusion criteria and list sources for the provider and consumer focus groups. State evaluation teams selected the providers for focus groups based on the providers’ practice setting and type of care they provide. Provider focus groups ranged in size from four to nine participants. Provider focus groups included medical doctors, dentists, and primary care (PC) physicians; nurses; physician assistants; and mental health professionals (*Table L-3*). The composition of the provider groups varied, reflecting state-specific emphases of the SIM Initiative across Model Test states. The topics of the provider focus group discussions centered especially on delivery transformation, workforce capacity, behavioral health integration, care coordination, and quality measurement and reporting.

Table L-2. Focus groups for Round 2 Model Test states, Annual Report 3 analysis period

State	Inclusion criteria	City	List source	Number of participants
Colorado	Providers			
	PCPs working in SIM-participating cohort 1 or 2 PC practices at least 40% of the time	Denver	State SIM team	9
	BH providers working in SIM-participating cohort 1 or 2 PC practices at least 25% of the time	Denver	Publicly available	8
Connecticut	Providers			
	PCPs (MDs/DOs, PAs/NPs, and RNs) in FQHCs or lookalike clinics participating in the PCMH+ program or Community and Clinical Integration Program	East Hartford	State SIM team	6
	Consumers			
	Medicaid beneficiaries enrolled in PCMH+	East Hartford	Director of the Division of Health Services in Connecticut’s Department of Social Service	7
	Medicaid beneficiaries not enrolled in PCMH+	East Hartford	Director of the Division of Health Services in Connecticut’s Department of Social Service	8
Delaware	Providers			
	Providers who have participated in PT	Wilmington	State SIM team	6
	Providers who have participated in PT	Milford	State SIM team	5
	Consumers			
	State employees insured by Highmark Blue Cross Blue Shield or Aetna	Wilmington	State SIM team	7
	State employees insured by Highmark Blue Cross Blue Shield or Aetna	Dover	State SIM team	7

(continued)

Table L-2. Focus groups for Round 2 Model Test states, Annual Report 3 analysis period (continued)

State	Inclusion criteria	City	List source	Number of participants
Idaho	Providers			
	PCPs participating in a State Health Improvement Plan cohort	Boise	IDHW	7
	PCPs not participating in a State Health Improvement Plan cohort	Boise	IDHW	5
	Consumers			
	Medicaid beneficiaries enrolled in a State Health Improvement Plan	Boise	IDHW	9
	Medicaid beneficiaries not enrolled in a State Health Improvement Plan	Boise	IDHW	6
Iowa	Providers			
	Emergency providers and PCPs (MDs/DOs, PAs, and APNs) contracted with a Medicaid MCO, with at least 10% of patients having Medicaid coverage (priority given to providers with C3 experience), and health coaches and care coordinators directly involved in referring patients to C3s	Knoxville	A complete list from the state Medicaid office and a list of providers who have C3 experience from the Marion County Public Health Department	5
	Emergency providers and PCPs (MDs/DOs, PAs, and APNs) contracted with a Medicaid MCO, with at least 10% of patients having Medicaid coverage (priority given to providers with C3 experience), and health coaches and care coordinators directly involved with referring patients to C3s	West Des Moines	A complete list from the state Medicaid office and a list of providers who have C3 experience from the Dallas County Public Health Department	7
	Consumers			
	Patients who have a Medicaid MCO plan (priority given to patients directly served by the local C3 initiative)	Knoxville	A complete list from the state Medicaid office and a list of patients served by C3s from the Marion County Public Health Department	8
	Patients who have a Medicaid MCO plan (priority given to patients directly served by the local C3 initiative)	West Des Moines	A complete list from the state Medicaid office and a list of patients served by C3s from the Dallas County Public Health Department	10

(continued)

Table L-2. Focus groups for Round 2 Model Test states, Annual Report 3 analysis period (continued)

State	Inclusion criteria	City	List source	Number of participants
Michigan	Providers			
	PCPs participating in the SIM PCMH Initiative	Jackson	MDHHS	5
	PCPs participating in the SIM PCMH Initiative	Flint	MDHHS	4
	Consumers			
	Medicaid beneficiaries enrolled in a certified PCMH	Jackson	MDHHS	8
Medicaid beneficiaries enrolled in a certified PCMH	Flint	MDHHS	6	
New York	Providers (MDs/DOs and PAs/NPs) in practices receiving TA to adopt New York's APC model	Brooklyn	NYSDOH	6
	Providers (MDs/DOs and PAs/NPs) in practices receiving TA to adopt New York's APC model	Jamaica	NYSDOH	8
Ohio	Providers			
	Principal accountable providers (allergists, immunologists, pulmonologists, emergency medicine physicians, obstetricians/perinatal providers, and PCPs)	Dayton	Ohio State Medical Association	7
	PCPs (in general practice, family medicine, or internal medicine)	Dayton	Ohio State Medical Association	6
	Consumers			
	Medicaid beneficiaries in the top half of expenditures who do not participate in MyCare	Dayton	State Medicaid office	8
Medicaid beneficiaries eligible for an episode-based payment for asthma, perinatal care, or chronic obstructive pulmonary disorder and who do not participate in MyCare	Dayton	State Medicaid office	8	

(continued)

Table L-2. Focus groups for Round 2 Model Test states, Annual Report 3 analysis period (continued)

State	Inclusion criteria	City	List source	Number of participants
Rhode Island	Providers			
	PCPs or BH providers in an integrated BH practice	Providence	State SIM team	9
	BH practitioners staffed at a CMHC that implemented the CMHC dashboard	Providence	Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals	8
	Consumers			
	Medicaid beneficiaries receiving treatment for a mental health or substance use condition	Providence	Executive Office of Health and Human Services	7
	Medicaid beneficiaries receiving treatment for a mental health or substance use condition	Providence	Executive Office of Health and Human Services	7
Tennessee	Providers			
	BH providers (psychologists, psychiatric/mental health nurses, and licensed professional counselors or other BH providers) who accept TennCare (Medicaid) and participate in Health Link	Nashville	Tennessee Division of TennCare	6
	PCPs (MDs/DOs, NPs, and PAs) who accept TennCare (Medicaid) and participate in the PCMH program	Memphis	Tennessee Division of TennCare	7
	Consumers			
	TennCare (Medicaid) beneficiaries	Nashville	Tennessee Division of TennCare	7
	TennCare (Medicaid) beneficiaries	Memphis	Tennessee Division of TennCare	7
Washington	Providers			
	Providers practicing at FQHCs likely to be directly impacted by Payment Model 2	Seattle	Washington HCA	7
	BH providers in the first region working in clinics that underwent Payment Model 1 Medicaid BH integration in MCOs	Vancouver	Washington HCA	7

(continued)

Table L-2. Focus groups for Round 2 Model Test states, Annual Report 3 analysis period (continued)

State	Inclusion criteria	City	List source	Number of participants
Washington	Consumers			
	Public Employee Benefits Board members (state employees) enrolled in the Accountable Care Program plan	Seattle	Washington HCA	9
	Medicaid beneficiaries enrolled in physical health- and BH-integrated MCOs who have used a BH service and visited a PCP within the past 12 months	Vancouver	Washington HCA	6

APC = Advanced Primary Care; APN = advanced practice nurse; BH = behavioral health; C3 = Community and Clinical Care (formerly Community Care Coalition); CMHC = community mental health center; DO = Doctor of Osteopathic Medicine; FQHC = Federally Qualified Health Center; HCA = Health Care Authority; IDHW = Idaho Department of Health and Welfare; MCO = managed care organization; MD = medical doctor; MDHHS = Michigan Department of Health and Human Services; NP = nurse practitioner; NYSDOH = New York State Department of Health; PA = physician’s assistant; PC = primary care; PCMH = patient-centered medical home; PCMH+ = Person Centered Medical Home Plus; PCP = primary care provider; PT = practice transformation; RN = registered nurse; SIM = State Innovation Model; TA = technical assistance.

Table L-3. Provider types participating in the provider focus groups

State	MD/DO/ PCP*	Nurse**	PA	Psychiatrist/ psychologist	Social worker/ counselor***	Therapist
Colorado	✓	✓	✓	✓	✓	—
Connecticut	✓	✓	✓	—	—	—
Delaware	✓	✓	—	—	—	—
Iowa	✓	✓	✓	—	—	—
Idaho	✓	✓	✓	—	—	—
Michigan	✓	✓	✓	—	✓	—
New York	✓	—	✓	—	—	—
Ohio	✓	—	—	—	—	—
Rhode Island	✓	✓	—	✓	✓	—
Tennessee	✓	✓	—	✓	✓	—
Washington	✓	✓	✓	—	✓	✓

✓ = participated; — = did not participate; DO = Doctor of Osteopathic Medicine; MD = medical doctor; NP = nurse practitioner; PA = physician’s assistant; PCP = primary care provider; RN = registered nurse.

*Includes prenatal, pediatric, and emergency medicine specialists.

**Includes RN and NP.

***Includes mental health and addiction.

Most consumer focus groups, ranging in size from 6 to 10 participants, involved Medicaid beneficiaries treated in a delivery setting that had participated in SIM-related transformation (*Table L-2*). Discussions focused on the quality of care and delivery transformation as related to access to care, support for self-care, chronic disease management, health care team composition, care coordination, behavioral health integration, and health IT.

The evaluation team used letters and telephone calls to recruit consumer and provider focus group participants. First, the evaluation team sent advance letters to potential participants that informed them about the data collection, introduced them to CMS and the evaluation team, and invited them to volunteer to participate. Next, the evaluation team performed telematch and other methods to remedy incomplete contact information. The evaluation team then used state-specific screening scripts to call focus group candidates to assess their eligibility to participate. During the calls, focus group candidates received information about compensation for travel, expected time commitments, and incentives (i.e., \$75 per consumer and \$300 per provider) to encourage their participation. To confirm participation and provide logistical details, recruiters re-contacted candidates who agreed to participate a few days prior to and again the evening before each focus group session.

A single evaluation team member moderated the focus groups for all 11 Round 2 Model Test states, with occasional co-moderation for a particular state by a state evaluation team member. Each focus group lasted less than 2 hours, including time to review the focus group processes and obtain informed consent. Focus group moderators used discussion guides customized for each state's SIM Initiative and obtained consent from each participant to audio-record the discussions. After each focus group session, the evaluation team had the audio recordings professionally transcribed and used the transcripts for all subsequent analysis.

L.3 Qualitative Data Analysis

Analysts from the evaluation team examined qualitative evaluation data in two steps. The first step involved using a structured coding process to combine data across sources into broad substantive areas relevant to delivery transformation and payment reform. The second step involved thematic analyses of data within substantive areas and then across those areas to draw larger conclusions regarding SIM implementation.

For the first step, the evaluation team combined qualitative data from the site visit interviews and focus groups, monthly evaluation calls, and progress reports for coding in NVivo qualitative analysis software. Analysts adopted a structured coding process to combine data from the disparate sources into broad substantive areas relevant to PT and payment reform (*Table L-4*).

Table L-4. Codes applied to qualitative evaluation data

Code	Definition
Leveraging regulatory authority	The extent to which and how regulations were used to transform health care
Overall SIM implementation	The implementation of the states' SIM Operational Plans
Governance	The management, coordination, and leadership of states' SIM Initiatives
Stakeholder engagement	Attracting and involving appropriate individuals regarding the implementation and use of the intervention
Sustainability	The extent to which SIM-related practices are being maintained or institutionalized within a service setting's ongoing, stable operations
Payment reform	Different strategies for financing health care delivery and how they have changed because of the SIM Initiative
Utilization and expenditures	Patient-level use of the health care system (e.g., office visits, emergency care visits, prescription fills) and associated costs (e.g., total cost of care, visit costs, medication costs)
Population health	Health outcomes of a group of individuals, including the distribution of such outcomes within the group (often assessed with respect to geographically defined communities)
Delivery transformation	Changes to how health care is delivered across settings
BH integration	The integration of mental health and substance use services with primary or physical health care
Care coordination	The deliberate organization of patient care activities between two or more providers involved in a patient's care
Workforce capacity	The extent to which health care professionals have the ability, availability, and resources needed to deliver care
Health IT	The array of technologies to store, share, and analyze health information
Preponderance of care	The proportion of a state population reached by delivery transformation and payment reforms
Quality of care	The degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge
Quality measurement	Tools and procedures that help measure or quantify the quality of health care processes, outcomes, patient perceptions, and organizational structure and/or systems

BH = behavioral health; health IT = health information technology; SIM = State Innovation Model.

Analysts developed the codes from interview protocols, evaluation research questions, and concepts known to be relevant from the team's existing subject matter expertise and the evaluation's previous years. Analysts annually reviewed and updated the coding structure to reflect the changing importance or relevance of concepts over time, thereby enabling the

evaluators to build on lessons and conclusions from the evaluation team’s previous experience on the project.

Analysts piloted the revised codebook in NVivo by using a sample of interviews and progress reports. The pilot effort helped to ensure that the coders understood the codes and applied them consistently to the same text. The pilot effort also allowed coders to recommend changes to the codebook. At the end of the pilot coding effort, analysts discussed challenging passages and resolved coding discrepancies resulting from ambiguity in the codes themselves or inconsistencies in how the codes were applied (e.g., length of coded passages, inclusion or exclusion of headers). Once the analysts had successfully addressed inconsistencies and other coders’ concerns, they finalized the codebook for use beyond the pilot data.

After analysts finished coding the remaining data, they generated code-specific reports, integrating information across data sources. State evaluation teams adopted an inductive approach to using these reports by reviewing them to identify key themes and patterns within and across substantive areas for each Model Test state. The approach initially allowed flexibility because the state evaluation team determined which themes and ideas were relevant for each state. The area-specific substantive leads adopted a similar approach for cross-state findings. Shared evaluation questions were used to help create alignment and continuity across states. Because NVivo segments code the reports by source name, evaluation team members could evaluate the consistency across different data sources and stakeholder types. Sometimes, outliers in the data—or conclusions that differ from those most commonly expressed—added nuance and richness to the analysis by encouraging evaluation team members to question and refine early impressions.

Findings underwent review and were further developed, as evaluation team members attended meetings and prepared documents to share their preliminary results, collect feedback from colleagues, and strengthen conclusions. After this iterative process, the evaluation team members reported the culminating analysis in a narrative for each state and across states that discussed the implementation successes and challenges encountered by the 11 Round 2 Model Test states.