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State Innovation Models (SIM) Initiative Evaluation

Model Design and Model Pre-Test Evaluation Report

Prepared for

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Glossary

Accountable care model: An organization that takes responsibility for all of a patient’s care, including care coordination and quality, and accepts financial risk for the care.

Bundled payment model: Payers offer a single payment—usually on a prospective basis—for all services rendered by multiple providers caring for a patient during an episode of care (a defined set of services over a defined time period).¹

Consumer engagement strategy: Activities directed specifically at changing consumer/patient behavior. Examples include patient-centered communication; changes in the clinical setting to activate patients in their own care, such as access to their own health information; and choice architecture within insurance plans to help consumers choose the highest-value health care services (e.g., value-based insurance design).

Data aggregation and analytics strategy: Development or enhancement of systems to maintain clinical, utilization, or expenditure data—or all three—in an aggregate manner for the purpose of providing population-level quality and cost information. Examples include All-Payer Claims Databases, public reporting of quality and cost, other data systems designed to provide aggregation of various data sources and analytics, and strategies designed to use population-level data to identify hot spots of disease burden or frequent utilization.

Delivery system model: How health care providers organize themselves to deliver health care to the patients they serve. Delivery system models vary according to the types of health care providers involved and the minimum threshold necessary for provider reorganization to satisfy the basic characteristics of the model. A delivery system model may be implemented in conjunction with any payment model.

Enabling strategy: An activity usually led by an entity outside of the health care delivery system to build or transform the infrastructure that supports health promotion and health care delivery.

Episode of care payment model: Payers offer a retrospective payment reconciled to a target price for all of the services rendered by one or more providers for a patient’s episode of care, defined as a set of services over a defined time period for a specific condition or procedure (Center for Healthcare Quality and Payment Reform (n.d.)).

Health Home model: Health homes, a variant of patient-centered medical homes, offer patients—usually those with medically or socially complex conditions—person-centered care and facilitate access and coordination across primary care and providers of mental health, substance abuse services, long-term services and supports, and other specialists. Section 2703 of the Patient Protection and Affordable Care Act gave states the statutory authority to provide health homes for Medicaid enrollees with chronic conditions through a state plan amendment to the Medicaid State Plan.

¹ This definition is different from the one used by Medicare in its Bundled Payment for Care Improvement Initiative (see <http://innovation.cms.gov/initiatives/bundled-payments/>), which includes both retrospective and prospective payments to single or multiple providers, but consistent with other sources (see Center for Healthcare Quality and Payment Reform. Transitioning to Episode-Based Payment, available at <http://www.chqpr.org/downloads/TransitioningtoEpisodes.pdf>).

Health information technology strategy: Activities to develop or enhance systems that maintain and transmit individually identifiable clinical data. Examples include health information exchange for communicating across providers, new adoption or increased use of electronic health records, use of secure messaging (email) with patients, and providing patient access to their own health information through secure web portals.

Infrastructure to support delivery system transformation: Organizations and policies that support technical assistance to practitioners within the health care delivery system. The focus of this assistance may be on the transition to a medical home, adoption of team-based care, improvement on certain health or cost outcome aims, integration with community resources, and readiness to participate in value-based payment models.

Long-term services and supports: Community- or provider-based capacity to help elderly or disabled individuals perform daily living tasks (Woodcock, 2011).

Patient-Centered Medical Home model: Primary care practices that adopt five core functions: comprehensive primary care services to children and adults that meet the majority of a person's physical and mental health needs, including preventive, chronic, and acute care; patient-centered care; coordinated care; accessible care; and commitment to quality and safety. The model also includes three enabling attributes to provide the supporting structure: health IT, workforce development, and payment models (AHRQ, 2014).

Payment model: How health care payers (insurance companies, Medicaid, Medicare) pay health care providers, with regard to who receives the payment (individual clinicians, individual institutions, or combinations), unit of payment (procedure or visit, course of treatment or episode of illness, care for a patient during a specified period of time), whether payment is prospective or retrospective with respect to when care is delivered, whether all or part of the payment is based on quality, and whether the provider bears risk for the cost or quality of care, and if so, what type of risk. The payment model could also include how payment is distributed to the component parts of a combination of providers and institutions.

Public health strategy: Activities to improve the health of populations that are not specifically patients of any one provider or payer. In contrast to a delivery system model of care, public health strategies are delivered outside of the health care delivery system to the general population. Often, a non-health care provider is responsible for promoting public health strategies, and in some cases, is the backbone organization to a defined coalition for health or accountable community for health. Common goals of public health strategies are to improve heart health, help with tobacco cessation, and reduce obesity in the general population through community-based activities or through closer relationships between clinical health care providers and non-health care organizations such as social services, schools, community development organizations, transportation, parks and recreation agencies, and civic groups.

Workforce development strategy: Policies and programs designed to enhance the existing health care workforce and add roles or professional categories not previously considered as part of the clinical workforce. Examples include policies that plan for future health care workforce needs, address workforce training, influence the distribution of the workforce within a state, and change the scope of practice laws or licensing requirements. The strategies may involve community health workers and other health-related personnel outside of the traditional health care delivery system.

Glossary References

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Executive Summary

The State Innovation Model (SIM) Initiative within the Center for Medicare and Medicaid Innovation (the Innovation Center) provides federal support to states to develop and test innovative health care delivery and payment system models designed to meet the specific needs of the states' residents and to achieve better health care, lower health care costs, and improved population health. The Initiative calls on states to engage multiple stakeholders and to build on existing health care system payment and delivery system transformation efforts. Each state's Health Care Innovation Plan included one or more innovative models for restructuring the state's health care system from volume-based to value-based purchasing; enabling strategies, such as workforce development and alignment of health information technology (health IT); and legislative and regulatory policy levers necessary to ensure the transformation reaches a preponderance of care provided in the state. The Initiative is designed to test whether health care delivery and payment transformation will have greater success when implemented in the context of a broad state plan as compared to individually implemented demonstrations.

The Innovation Center awarded 16 states Model Design funding to produce a Plan. An additional three states that had submitted proposals for Model Test awards were awarded Pre-Test funding to continue work on their Plans, and six states were awarded Model Test funding. This report focuses on the experience of the Model Design and Pre-Test states in engaging a broad array of stakeholders and designing a Plan that meets the goals of the Initiative. For both groups of states, funding began April 1, 2013, and the states were to submit their completed plans to the Centers for Medicare & Medicaid Services (CMS) by October 30, 2013. However, the Innovation Center granted a 2-month no-cost extension to states that requested it; five states received an additional extension to March 31, 2014.

The team of RTI International, The Urban Institute, and the National Academy for State Health Policy was awarded a contract to evaluate the SIM Initiative, including the planning process and resulting Plans of the Model Design and Pre-Test states. For this component of the evaluation, the RTI team assessed the states' ability to: (1) bring together a broad range of stakeholders into their design process, (2) obtain multi-payer commitment to value-based payment, (3) engage their executive and legislative authority to facilitate and support their Plans, (4) coordinate with other related initiatives, and (5) encompass a preponderance of the care provision in the state into their Plans.

For each of the 19 states, the evaluation team synthesized data from key informant interviews, observation of stakeholder and work group meetings, and document review to produce a case study. The Model Design and Pre-Test state evaluation teams completed a total of 264 interviews. Nine to 20 interviews were conducted in each state, most by telephone but some in person. Interviewees included state officials, public and private payers, providers and

representatives of provider associations, health care infrastructure support personnel, consumer advocates, employer groups and other purchasers, and state contractors. Evaluation teams for 12 states attended 45 stakeholder and work group meetings, either in person or by telephone. Evaluation teams in all states reviewed materials and deliverables the states created for the Innovation Center, including the state's SIM Model Design application (or in the case of the Pre-Test states, the Model Test application), the state's stakeholder engagement plan, state quarterly reports, and the final State Health Care Innovation Plan. When available, evaluation teams also reviewed stakeholder or work group meeting agendas, slides, and written summaries; white papers, policy briefs, and technical reports related to existing initiatives in the state or prepared during the planning period; existing or proposed legislation; state Web sites relevant to the SIM initiative or related programs; public comments on the draft or final Plan; and press reports concerning the state's SIM initiative, planning process, or related health care reform efforts. To identify key themes for analysis, all interviews were coded in NVivo and standardized abstraction tools were developed for the meetings and document review.

In addition to the 19 individual state case studies, we conducted a cross-state analysis of the planning and stakeholder engagement processes used and the delivery and payment system models, enabling strategies, and policy levers proposed in the Plans. In addition, we highlighted lessons learned from the states' perspective and summarized their recommendations to CMS for future health care reform efforts.

Results

The Plans developed in all Model Design or Pre-Test awardee states included various combinations of delivery system and payment models, enabling strategies to support changes in the health care delivery and public health system, and policy levers to facilitate Plan implementation. In part, this results from each state's own political and policy environment, existing initiatives, health care market, and range of stakeholders involved in the planning process.

State context for Plan development. Most states with Model Design or Pre-Test awards leveraged the support and leadership of the Governor's Office to facilitate the planning process and garner support from public and private sectors. In contrast to the mostly consistent executive branch leadership observed in each state, other starting conditions for planning varied across states along several dimensions—including the degree of state experience with statewide health care system program and policy planning, Medicaid involvement in prior delivery and payment system change, commercial health plan experience with models of delivery system and payment innovation, health care workforce, health IT infrastructure available, and existence of all-payer claims databases (APCDs).

Planning process. To complete the Plan development process within the initial 6-month time frame, most states assigned leadership for the SIM Initiative to a state employee, usually within the Governor's or Lieutenant Governor's Office, Medicaid agency, or other state health department or agency. The SIM leadership in each state often contracted with an external consulting group to augment staff resources needed to convene multi-stakeholder meetings, communicate to a broad array of stakeholders, conduct research, and contribute to drafting the Plan. Most states set up work groups of public and private sector stakeholders to develop Plan proposals over the course of several months, although there were exceptions. In most cases, the SIM leadership recruited individuals to join new work groups for the short-term assignment of Plan development, rather than engaging existing commissions or coalitions to contribute to the Plan. The Innovation Center offered technical assistance to states' SIM leadership and their stakeholders; use of this assistance varied by state and is reported separately.

To solicit public comment, some states posted draft versions of their Plan on a public Web site, and others circulated drafts by email. In other states, only the Innovation Center and the SIM initiative evaluators received the final Plan. States' SIM leaderships varied as to how they decided the final Plan content. Some states vetted their Plan with an existing advisory group of cabinet-level state officials; some used a consensus or voting process within groups of both public and private stakeholders; and in others, SIM leadership was responsible for finalizing the Plan after formally or informally consulting with various stakeholders.

Stakeholder engagement. The Innovation Center expected states to involve many types of individuals and organizations in developing the state Plan, and all states did solicit input from a broad range of stakeholders using a variety of methods. These stakeholders included state agencies and local government entities; providers (health care, behavioral health, long-term services and supports [LTSS]); health plans and payers and self-insured employers; health care system infrastructure (such as public hospitals and academic medical centers, health information exchanges, policy institutes, quality improvement organizations, and foundations); consumers, advocates, and community leaders; and social service organizations. The degree to which these stakeholders had the opportunity to give one-time comments, or were involved in the ongoing deliberation of the Plan, often depended on the state's initial focus for the Plan and the structure states established to involve public and private sector partners in Plan development.

State Plans. The states took differing approaches to addressing the SIM Initiative aims of better health care, lower health care costs, and improved population health. Some states focused on primary care practice transformation to patient-centered, coordinated care; others focused on the integration of primary care providers and providers of acute care, behavioral health services, or LTSS, or the integration between health and social services. Most of the models proposed by states included some form of payment reform, moving from a volume-based payment system to a value-based one, often in a phased-in approach with providers taking on

more risk over time. In some states, adoption of value-based purchasing was the main focus, with no single delivery system model favored over another. Many state Plans had multiple foci, and all included enabling strategies designed to facilitate, promote, and sustain the health system transformation envisioned in the proposed models.

All states included one or more of four major delivery system and payment models in their Plans: (1) patient-centered medical homes (PCMHs), (2) health homes for medically complex populations, (3) integrated or accountable care systems, and (4) episode of care (EOC) payment models.

- *PCMHs* were included as part of 13 states' Plans. PCMHs provide whole person-oriented care that meets most of a patient's physical and mental health care needs and is delivered in the context of coordinated, team-led care. Primary care transformation to PCMHs was the centerpiece of eight state Plans. In three other state Plans, primary care PCMHs were the foundation of integrated care systems, such as accountable care organizations (ACOs); and in two other state Plans, they were one of several models promoted for the states' transformation to value-based purchasing.
- *Health homes*, a variant of PCMHs geared toward medically complex patient populations and the providers serving them, were core models in four states' Plans.
- *Accountable care* models were included in eight states' Plans. In these models, groups of providers—including physicians, hospitals, and other health practitioners—come together to work collaboratively and accept accountability for the cost of care for a defined set of patients. Accountable care models were proposed as the cornerstone of efforts to move to integrated, value-based care in six states; in the two others, they were only one of multiple models the state would promote to achieve value-based purchasing.
- *EOC* models were included in three states' Plans. In these models, either a designated provider receives a prospective payment for a specific illness or course of treatment, or total expenditures across participating providers are retrospectively reconciled to a target price. In all three states' Plans, the EOC models were only one of multiple delivery system and payment models proposed.

That PCMH models were the most common model type included in state Plans is not surprising, because the PCMH model has been implemented in many states already, several organizations offer a standard definition for the purposes of recognition or certification, and a growing body of evidence exists on the effects it has on provider and patient outcomes. In contrast, the concepts of accountable care and EOC models are relatively new, and stakeholders

in several states questioned whether there is sufficient evidence on their results with regard to patient and financial outcomes.

In addition to these delivery system and payment models, many states' Plans included delivery system enhancements focused on a particular dimension—such as expansion of behavioral health services or LTSS, integration of these services with the physical health services, or care for special population groups (including pregnant women, individuals at the end of life, and medically or socially complex patients).

States also proposed a variety of enabling strategies to promote, build, or transform the infrastructure that supports health care delivery and payment or enhances their effectiveness. Some of these enabling strategies followed from the guidance the Innovation Center gave to states about the content of the Plan—including workforce development, health information technology (health IT) and data infrastructure, and the coordination with or integration of public health approaches. Two other enabling strategies emerged from the planning process: (1) development of organizations or policies to support providers' adoption of new delivery and payment system models, and (2) mechanisms for engaging consumers in their health and health care.

Policy levers. Policy levers facilitate implementation of proposed models and strategies, and encompass laws; regulations; and state or federal agency policies, activities, and programs. Each Model Design and Pre-Test state proposed a different mix of policy levers, even when proposing to implement similar models and strategies. This occurred for three major reasons. First, the diversity in laws, regulations, and approach to policy-making across the states yields a different roadmap for Plan implementation in every state. For example, states with a robust regulatory mechanism for reviewing health insurance plans (e.g., New York and Rhode Island) propose to use regulation to align payers around a common delivery system and payment model. Second, in some states, the roadmap for Plan implementation included undoing existing policy specific to that state. Third, states' Plans left some policy levers to be determined, either because they avoided a potentially controversial topic intentionally, discussed it but did not have the stakeholder consensus to support any particular policy lever, or believed voluntary agreement would be sufficient for widespread implementation.

Potential for implementation. Most states' Plans were consistent in identifying additional federal funding—through a Model Test award or other grant funding—as an important factor for implementation of the proposed models and enabling strategies. Many states planned to use this additional funding to support the proposed enabling strategies—particularly those having to do with providing technical assistance and support for delivery transformation—and for the HIE and data infrastructure and analytics capacity to support the new delivery and payment models. Most states considered some aspects of the Plan as feasible in the absence of a Model Test award or additional funding; typically these were components involving Medicaid,

Medicaid managed care, or state employee health reforms, which are clearly under the control of the state. Voluntary cooperation among payers and providers was an approach proposed by many states; the extent to which states were able to secure agreement among these stakeholders during the planning process varied.

Lessons learned. Interviews with stakeholders provided lessons learned for other states preparing Plans. The lessons covered leadership, stakeholder engagement, time and resource requirements, processes, and the resulting Plan features.

- *Leadership:* Most interviewees saw the state as an appropriate and necessary leader of an effective health care transformation planning process. The Governor's support provides visibility and instills the importance and credibility needed to engage stakeholders in the process. Furthermore, the state as a major payer and regulator in the health care market yields significant power and influence to make reform happen. However, interviewees noted that the state's reach is limited and that for successful design and implementation of a state-led health care transformation effort, states must develop a partnership with both state-based and national private and other public sector interests.
- *Stakeholder engagement:* In general, interviewees believed that failing to include all affected stakeholders from the beginning of the planning process would affect the Plan design and may reduce buy-in and encumber Plan components that rely on voluntary actions during implementation. Early and meaningful engagement of stakeholders allows them time to develop and provide feedback on multiple iterations of the Plan. Work group participation allows a variety of stakeholders to be involved in the planning process in a meaningful and productive manner.
- *Time and resources:* A short timeframe, like the one for the SIM Model Design phase, can keep participants focused and engaged, but it can also preclude consideration of novel or controversial ideas, development of detailed plans, and consensus from key stakeholders. Having a dedicated staff for Plan development, either from within state government or through the use of external consultants and contractors, is critical to working within the time frame.
- *The process:* Stakeholders found front-end planning to be crucial. Of particular importance was gathering information on delivery and payment system reform efforts both within the state and in other states, including the costs and return on investments of different transformation strategies. Once gathered, this information must be effectively communicated to stakeholders in an understandable and unbiased manner. Throughout the planning process, stakeholders should be kept apprised of the deliberations and decisions. Tailored communication tools and methods may need to be developed and used with different stakeholder groups.
- *The Plan:* The interviewees agreed that states should build on existing models within their states. Stakeholders are familiar with the models, increasing the likelihood of

their support. In addition, these models are more likely to yield success early on; the states can then use the success of these programs to argue for moving forward with a bigger initiative. At the same time, though, states should allow for the submission, discussion, and integration of novel, innovative ideas into the Plan.

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1. Introduction

The State Innovation Model (SIM) Initiative within the Center for Medicare and Medicaid Innovation (the Innovation Center) provides federal support to states to develop and test innovative health care delivery and payment system models designed to meet the specific needs of the states' residents and to achieve better health care, lower health care costs, and improve population health. The Initiative calls on states to engage multiple stakeholders and to build on existing health care system payment and delivery system transformation efforts. The Initiative is designed to test whether health care delivery and payment transformation will have greater success when implemented in the context of a broad state plan as compared to individually implemented demonstrations.

States have several characteristics that position them well to facilitate changes in the health care system leading to improvement in population health and lower costs. First, the Governor is publicly accountable and responsible for a large proportion of health care spending in a state. Among the motivations for state Governors to prioritize health system change are the increasing cost of state-funded health care through Medicaid, state employees, and state retirees; pressure from employers facing similar costs; and concerns from the public about health care quality and patient experience (Crippen and Isasi, 2013). Second, states are the locus of most essential public health functions, such as assessing population-level health risks and health status and ensuring a competent health care workforce (e.g., through licensure authority). Third, in their roles as regulators of market-based insurance, states can significantly affect both the costs of insurance coverage and payer participation in health care transformation. In addition, states set policies for regional planning, environmental health, education, and economic development that influence social determinants of health.

At the same time, several factors make large-scale, state-led changes in health care rare. For example, health insurance benefits offered by self-insured employers are exempt from state-based regulations on health insurers. Additionally, health insurance carriers that operate in more than one state may resist aligning with state-specific priorities; states with few insurance carriers in their market may be reluctant to pass mandates on insurers that would cause insurers to leave the state. Furthermore, shifting politics and the electoral cycle make it difficult to convince private sector stakeholders to invest in one policy direction if the next administration will likely change course.

1.1 Model Design and Pre-Test Awards

On February 21, 2013, the Innovation Center awarded funding to 19 states to produce State Health Care Innovation Plans. Sixteen states received funding as Model Design states to develop and submit a Plan. Three additional states that had applied to become Model Test states received Pre-Test awards to work further on their Plans. For both groups of states, funding

began April 1, 2013, and the states were to submit their completed plans to the Centers for Medicare & Medicaid Services (CMS) by October 30, 2013. However, the Innovation Center granted a 2-month no-cost extension to states that requested it; five states received an additional extension to March 31, 2014.

The Innovation Center communicated expectations of the Model Design and Pre-Test states in two stages. First, in the pre-award time period, the funding opportunity announcement served as a guide to the models, strategies, and policy levers states should consider in developing their Plans, and the set of stakeholders that should be involved. The funding opportunity announcement also described the expectation that a Plan would affect a “preponderance” of the population within a 3-year time period. Second, in the early months of the award period, the Innovation Center used Web-based meetings and other direct communication with awardees to clarify that Plans should address delivery of care for at least 80 percent of the state population, and to emphasize the importance of considering policies and factors outside the health care system that influence population health.

CMS contracted with the team of RTI International, The Urban Institute, and the National Academy for State Health Policy to evaluate the SIM Initiative, including the planning process and resulting Plans of the Model Design and Pre-Test states. For this component of the evaluation, the RTI team assessed whether the states were able to: (1) bring together a broad range of stakeholders into their design process, (2) obtain multi-payer commitment to value-based payment, (3) engage their executive and legislative authority to facilitate and support their Plans, (4) coordinate with other related initiatives, and (5) encompass a preponderance of the care provision in the state into their Plans.

Using key informant interviews, observation of stakeholder and work group meetings, and document review, the RTI team prepared a case study for each of the Model Design and Pre-Test states and a cross-state synthesis of the results. Specific research questions addressed in the state case studies and the cross-state analysis include the following:

- *State context.* What starting conditions in the state—such as health information technology initiatives, health care workforce and service sector composition, existing Medicaid or Children’s Health Insurance Program payment policies and waivers, and characteristics of the commercial health insurance marketplace—influence the planning process and ultimate Plan content?
- *Planning process.* Who led the planning process in each state? What processes did the state use to develop its Plan? What successes and barriers arose during the process? What was the consequence of the time and resources available for planning?

- *Stakeholder engagement.* Was the state able to actively engage the stakeholders during the planning process? What stakeholders were engaged and how were they engaged? What stakeholders were not engaged and why were they not engaged?
- *Models considered.* What kinds of payment and delivery system changes were proposed? Did states propose something other than medical or health homes, accountable care, and bundled payments for care or episodes of care? What populations were considered as the focus for these models? What payers would adopt these models under the Plan?
- *Strategies considered.* What strategies to influence the structure and performance of the health care system did the state consider? How will those strategies support the payment and delivery system models that states proposed?
- *Policy levers.* What legislative and regulatory changes did states propose to make to facilitate Plan implementation? What do states expect to accomplish with executive branch action, including persuading private sector entities to make voluntary changes? What other levers do states expect to use to ensure implementation of the proposed models and strategies?
- *Potential for implementation.* How do stakeholders perceive the feasibility of implementing the proposed models or strategies? Are states with Pre-Test awards more prepared to implement their proposed model as compared to the Model Design states? Are the proposed models in any state able to be implemented with or without SIM Round 2 funding? What aspects of the Plan, if any, are already under way or will be implemented even if additional funding from the Innovation Center is not available?
- *Lessons learned.* What factors were associated with the successful development of the Plan? Is the state's success likely to be replicable in other states? What would Model Design and Pre-Test states recommend to other states that may undertake a similar statewide planning process? What recommendations do stakeholders in Model Design and Pre-Test states have for the Innovation Center's future work?

1.2 Report Outline

Chapter 2 describes the methods we used to analyze the experience of the Model Design and Model Pre-Test states. Chapter 3 describes the planning processes used in the Model Design and Pre-Test states, the models and strategies proposed in their final Plans, and policy levers identified to facilitate Plan implementation. Chapter 4 summarizes lessons learned from across the states for establishing a planning process and structure, engaging stakeholders, and identifying models and strategies that improve the delivery of health care, lower health care costs, and meet the specific needs of the states' residents. Chapter 4 also includes states' recommendations for CMS. In chapters 6 through 25, respectively, we provide case studies of

the process each state used to develop its Plan and the results of that Plan (both content and stakeholders' assessment of its feasibility).

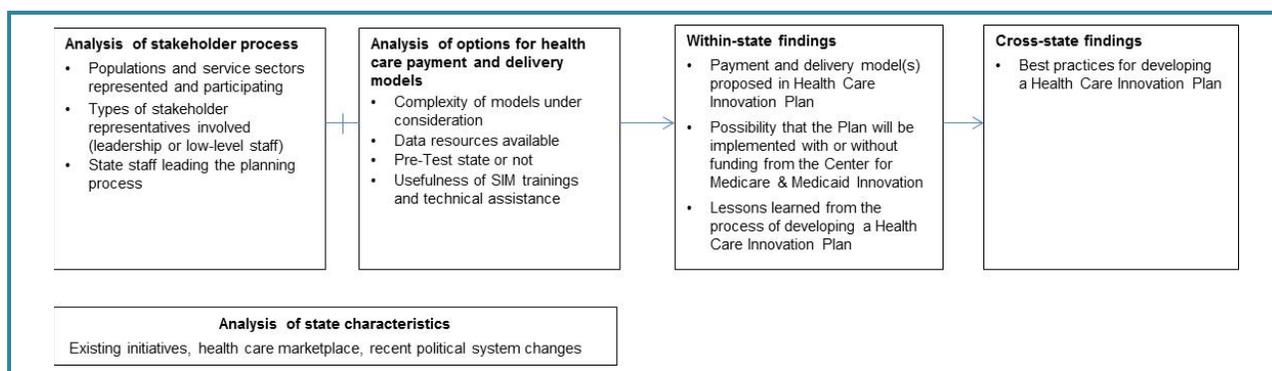
2. Methods

To conduct the State Innovation Model (SIM) Initiative Model Design and Pre-Test evaluation, the RTI team prepared 19 state case studies using a standardized theoretical framework, standardized data collection approaches and instruments, and a common reporting outline. We then used the case studies to identify common themes across states.

2.1 Framework for the Evaluation

For each Model Design and Pre-Test state, we conducted a case study of the Plan development process and outcome. A graphic presentation of our approach is shown in [Figure 2-1](#). The framework is adapted from Community Coalition Action Theory, which predicts how health and social outcomes emerge from a community-based stakeholder process (Kegler and Swan, 2011). We considered the influence of the following constructs on the Plan outcome: (1) stakeholder composition, the process for obtaining stakeholder input, and the weight given to input in the decision-making process; (2) the options presented and the information and data analyses available for assessing and comparing options; and (3) the state characteristics that influence the formation of stakeholder groups, decisions states make, and outcomes. These characteristics include such factors as existing initiatives, the health care marketplace, and political system changes.

Figure 2-1. Framework for the SIM Model Design and Pre-test state evaluation



Abbreviations: SIM = State Innovation Model.

We describe two outcomes for each state’s Plan development: (1) the payment and delivery system models proposed in the Plan and (2) the state’s intentions for implementing the Plan with and without funding from the Center for Medicare & Medication Innovation. From an analysis of the individual results, we then describe common lessons learned from the process of developing a Health Care Innovation Plan and best practices for states that have not yet embarked on the process.

2.2 Data Collection

We collected data for the evaluation by conducting semistructured interviews with key informants, observing stakeholder meetings, and reviewing existing documents and secondary data. The period of data collection varied by state, but primarily took place between August and December 2013. All final Health Care Innovation Plans were available by April 2014 and included in this analysis. A state evaluation team consisting of a leader and supporting staff was responsible for all data collection in each state. Additional staff provided data collection quality assurance across state teams and analysis to identify cross-state themes. RTI's Institutional Review Board exempted the SIM Model Design/Pre-Test evaluation from human subjects review on July 2, 2013.

2.2.1 Interviews with Key Informants

The evaluation team identified six types of key informants (See [Figure 2-2](#)) and developed interview guides for each type. The interview guides included sections on state context, planning and deliberative process, stakeholder engagement and management, components of the Plan, and feasibility. Each guide contained the same five sections, but the number of questions, follow-up probes, and order of questions varied by type of key informant. Task leads provided training to all state evaluation teams on each interview guide and the general interview protocol, including key informant selection, invitation, scheduling, note taking and recording, and confidentiality.

Each state evaluation team selected interviewees and conducted the interviews. The teams selected key informants for possible participation based on document review, background knowledge, and recommendations from state officials responsible for the SIM Initiative in the state. Each state evaluation team (independent of the state or the Centers for Medicare & Medicaid Services [CMS]) contacted potential interviewees by email to assess their interest in participating, and scheduled an interview with individuals who agreed to participate. A lead interviewer and a note taker from each state evaluation team conducted each 60- to 90-minute interview by phone or in person. They customized, within certain parameters, one of the six available interview guides to make the questions as relevant to the interviewee as possible. When requested, the evaluation team interviewed more than one person representing the same organization during the same interview.

Figure 2-2. Types of key informants interviewed for the SIM Model Design and Pre-Test state evaluation

- State officials
- Payers
- Providers (individuals and health care systems)
- Consumer advocates (consumers, patients, and caregivers)
- Health care infrastructure supports (e.g., directors from state health information exchange, regional quality improvement coalition)
- Other

Table 2-1 summarizes by stakeholder type the number of interviews conducted in each state. The Model Design and Pre-Test state teams completed a total of 264 interviews. Nine to 20 interviews were conducted in each state. A little over one-third (91) of the interviews were with state officials; 21% (55) were conducted with providers or provider associations; 15% (39) with payers; 13% (34) with health care infrastructure supports; 10% (27) with consumer advocates; and 7% (18) with other stakeholders, including employer groups, state contractors, market experts, and purchasers.

Table 2-1. Interviews conducted in SIM Model Design and Pre-Test states by stakeholder type and state

| State | State | | Providers | Consumer Advocates | Health Care Infrastructure | | Total |
|---------------|-----------|-----------|-----------|--------------------|----------------------------|-----------|------------|
| | Officials | Payers | | | Supports | Other* | |
| California | 4 | 3 | 2 | 3 | 4 | - | 16 |
| Colorado | 8 | 2 | 3 | 2 | 2 | - | 17 |
| Connecticut | 3 | 1 | 3 | 3 | 1 | 2 | 13 |
| Delaware | 3 | 1 | 3 | 1 | 1 | 1 | 10 |
| Hawaii | 5 | 1 | 2 | 1 | 3 | - | 12 |
| Idaho | 3 | 1 | 4 | - | 1 | - | 9 |
| Illinois | 4 | 3 | 5 | 2 | 2 | - | 16 |
| Iowa | 3 | 2 | 4 | 1 | 1 | - | 11 |
| Maryland | 5 | 2 | 4 | 2 | 2 | 1 | 16 |
| Michigan | 6 | 3 | 3 | 1 | 2 | - | 15 |
| New Hampshire | 3 | 3 | 3 | 3 | - | 2 | 14 |
| New York | 7 | 1 | 2 | 3 | 2 | 1 | 16 |
| Ohio | 4 | 3 | 3 | 2 | 2 | 1 | 15 |
| Pennsylvania | 10 | 1 | 4 | - | 1 | - | 16 |
| Rhode Island | 2 | 2 | 2 | 1 | 1 | 2 | 10 |
| Tennessee | 4 | 3 | 3 | 1 | 2 | 1 | 14 |
| Texas | 2 | 2 | 2 | - | 3 | 3 | 12 |
| Utah | 7 | 1 | 1 | 1 | 1 | 1 | 12 |
| Washington | 8 | 3 | 2 | - | 3 | 4 | 20 |
| TOTAL | 91 | 39 | 55 | 27 | 34 | 18 | 264 |

*Other stakeholders included employer groups, state contractors, market experts, and purchasers.

Each state evaluation team produced nearly verbatim notes for each interview based on the note taker's real-time notes supplemented by an audio recording of the interview when needed. The lead interviewer reviewed the completed notes for accuracy prior to coding and analysis.

2.2.2 Observation of Stakeholder Meetings and Workgroups

When possible, state evaluation teams attended stakeholder meetings and workgroups in person or by telephone. Some states had nearly finished their formal stakeholder meetings by the time the teams began to contact them (mid to late July). Because the original Model Design planning period was scheduled to end by October, meeting selection was based largely on timing rather than the meeting agenda or participants. Between July and December 2013, state evaluation teams observed 45 meetings in 12 states.

State evaluation team members attending stakeholder or workgroup meetings participated as observers. In this capacity, they took notes using a structured abstraction tool that captured a description of the stakeholder group and the people involved, purpose of the meeting, how the meeting was organized and facilitated, relationships observed, and key points from the meeting that either contradicted or supported information from other sources (e.g., document review or stakeholder interviews). The state evaluation team cleaned notes from observed meetings and reviewed them for accuracy prior to analysis.

2.2.3 Document Review

State evaluation teams reviewed documents and other narrative sources of information relevant to SIM Initiative efforts in each state. *Figure 2-3* lists the types of materials reviewed. In addition to the documents required by CMS SIM award terms and conditions, state evaluation teams reviewed several other types of materials, though not all types were available in each state. A structured abstraction template was used to guide document review and included sections for SIM goals, existing state infrastructure, SIM planning processes, stakeholder engagement, and models and policy levers considered for the Plan. However, not all documents reviewed contained information relevant to all sections of the template. State evaluation team leads in each state reviewed the key elements drawn from this abstraction process for accuracy prior to analysis.

2.2.4 Secondary Data

State evaluation teams also reviewed secondary data relevant to the state's starting conditions, including health care market statistics and population health measures. This included the State Health Access Data Assistance Center State Profile and the specific population health measures compiled by the Centers for Disease Control and Prevention for states as part of their planning efforts. Additional data reviewed included disability population statistics, population health measures (e.g., infant mortality, life expectancy at birth, heart disease deaths), selected workforce statistics, and additional health care market statistics related to mental health. The time period represented by the secondary data varied, depending on data source and state.

Figure 2-3. Materials reviewed for the SIM Model Design and Pre-Test state evaluation

Reviewed in All States

- State’s SIM Model Design application
 - State’s stakeholder engagement plan
 - State quarterly reports
 - State Health Care Innovation Plan
-

Reviewed if Available

- Stakeholder or workgroup meeting agendas, meeting slides, and written summaries
 - White papers, policy briefs, technical reports, and other documents prepared during the SIM planning period to guide the state’s Plan
 - Existing white papers, policy briefs, technical reports, and other documents related to preexisting state health care or public health initiatives, programs, or infrastructure
 - Existing or proposed legislation
 - State’s SIM Initiative Web site
 - Public comments on the Plan and the state’s response
 - Press reports concerning the state’s SIM Initiative, Plan, or related health care reform efforts
-

Abbreviations: SIM = State Innovation Model.

2.3 Data Analysis

Each state evaluation team was responsible for developing their state’s case study using their review of documents, coded notes from interviews with stakeholders, notes taken during stakeholder and workgroup meetings, and analysis of extant secondary data. In addition to the state case study, each team produced bullet points drawn from coded interview notes on the topics of technical assistance and recommendations for CMS.

2.3.1 Compiling and Coding Notes

We used QSR NVivo versions 9.2 and 10 (www.qsrinternational.com) to code the interview notes and assist in report writing. We developed an initial list of codes based on our evaluation logic model, interview protocol, and field experiences. During the pilot test of the code book, a small team of coders each coded the same interview and discussed coding differences. We achieved a reasonable rate of inter-rater reliability after modifying the initial pilot test and retesting the set of codes and definitions.

The final coding scheme allowed us to identify key topics and substantive information based on the interview data by state, respondent type, and (if applicable) date of interview (Miles and Huberman, 1994; Bradley, Curry, and Devers, 2007). We developed a codebook with

mutually exclusive definitions for all codes and examples to help coders know when to apply codes to the text within a set of interview notes. All coders received training on how to use the codebook, either in a group session or through individual consultation. All staff who coded interview notes from the same state met to resolve any variation in approaches to applying the codes within each state. Further, to ensure the data were coded consistently and objectively, task leaders reviewed at least one coded interview in each state to ensure consistent application of the codebook across states.

2.3.2 State Case Study Analytic Approach

In a case study approach, researchers use multiple sources of data to describe and analyze a set of events that evolved out of a particular context (Yin, 2009). Each state evaluation team used primary and secondary data—mostly qualitative, but some quantitative—to develop a case study for each state centered on the constructs described in the logic model: the background context, including existing initiatives and political and policy context; approaches to engaging a multi-stakeholder process to develop a Health Care Innovation Plan; and the content of the Plan that resulted, including comments on its feasibility. State evaluation teams used a variety of well-established techniques and guidelines to analyze the qualitative data from coded interview notes, meeting notes, and document review and extant secondary data in order to construct each state’s case study. These techniques included noting patterns and themes, drawing contrasts and comparisons, building a logical chain of evidence, assessing representation, and triangulating multiple data sources (Miles and Huberman, 1994, Devers, 1999; Weiner et al., 2011; Devers, 2011).

State evaluation teams sent each state’s draft case study to the SIM Initiative lead in that state to conduct a fact check, which took place in February, March, and April 2014. State evaluation teams used information from this fact check to update the state case study with regard to the status of legislation or other activities that could influence the potential for Plan implementation. However, as noted in the limitations section of each state case study, the state evaluation teams could not include perspectives on new developments in the Plan or Plan implementation after December 2013 from stakeholders other than the SIM Initiative lead in each state.

2.3.3 Cross-State Analysis

The 19 individual state case studies and final Plans from each state formed the basis for the cross-state analysis. The evaluation team identified multiple dimensions for comparison, related to the planning process, stakeholder engagement methods, and Plan components—including delivery and payment system models, enabling strategies, and policy levers proposed. We also highlighted cross-state lessons learned.

3. Cross-State Analysis

Through the State Innovation Models (SIM) Initiative, the Centers for Medicare & Medicaid Services' (CMS's) Innovation Center provided support to states to develop Health Care Innovation Plans (the Plans) to transform their health care system. The Plans should identify health care delivery and payment system models that support better care, improved health, and lower per-capita health care costs. States are charged with engaging multiple stakeholders, building on existing state payment reform and delivery system improvement efforts, using policy and regulatory levers to drive the transformation, and reaching a preponderance of health care by the end of the 3-year operational period.

This chapter presents an overview of the planning processes the states used to develop their Plans (Section 3.1) and the resulting models and strategies comprising the Plans (Section 3.2). Sections 3.3 through 3.5 describes three basic types of models proposed by the states—patient-centered medical homes (PCMHs)/health homes, accountable care, and episode of care (EOC) payment, respectively. These sections describe variations in the states' proposed application of the models, policy levers proposed by the states to authorize or facilitate model adoption or spread, and the states' implementation plans. Section 3.6 describes other system enhancements proposed by the Model Design and Pre-Test states in their Plans. Finally, Section 3.7 describes the enabling strategies proposed by states to support payers and providers in implementing the proposed delivery and payment system changes, including workforce development, health information technology (health IT) infrastructure, data aggregation and analytics, public health approaches, other system transformation infrastructure, and consumer engagement strategies. Section 3.8 concludes the chapter.

3.1 Planning Process

Funding to the Model Design and Model Pre-Test states under the SIM Initiative began April 1, 2013. States were to complete their Plans within the original 6-month period of performance. However, the Innovation Center granted a 2-month no-cost extension to states that requested it; five states received an additional extension to March 31, 2014.

States varied in their prior experience convening health care stakeholders for the purpose of transforming the health care system, the Governor's involvement in the planning process, SIM Initiative leadership and use of consultants, the formal structure of the planning process, and methods for and timing of stakeholder engagement. These features were all mentioned by stakeholders as having significantly shaped the results of the Model Design/Pre-Test planning process.

3.1.1 State’s Prior Experience in Health System Transformation Planning

Most Model Design and Pre-Test states had prior experience in convening health care stakeholders on a formal commission, 1-day summit, or ongoing health system planning process that served as a foundation for developing the SIM Initiative Plan. In Connecticut, Illinois, and Washington, SIM leadership incorporated an existing infrastructure—such as a public-private advisory board or council of state agency directors—into their stakeholder engagement work. In three other states, the SIM Initiative was the natural continuation of a state-based initiative to motivate health system change—Let’s Get Healthy California, Hawaii Healthcare Project, and the Ohio Office of Health Transformation’s priorities. These states had more time and funding to identify action steps and policy levers. In several other states, including Delaware, Iowa, Maryland, and Utah, previous efforts prepared stakeholders to participate in the planning process by giving them the baseline knowledge of health care system facts or buy-in on the priority areas for reform. State SIM leadership drew on existing relationships formed through these prior efforts to recruit participants to the process of Plan development.

3.1.2 State Sponsorship

The Governor, Lieutenant Governor, or both had an active role in facilitating the Plan development process in all but a few states. In Delaware, Ohio, and Washington, the Governor convened employers, commercial health plans, and other key stakeholders to encourage their participation in the planning process and buy-in to the goals. In Connecticut, Rhode Island, and Utah, the Lieutenant Governor was a champion for the SIM Initiative; in Colorado, the Lieutenant Governor convened discussions with tribes. In six states, the Governor’s Office or Lieutenant Governor’s staff led the planning process (Hawaii, Illinois, Iowa, Ohio, Rhode Island, and Utah).

In contrast to the significant involvement of the executive branch, SIM leaders in most states did not formally reach out to state legislators. However, Delaware and Idaho included two state legislators in their leadership team; Utah included a legislator as a member of its executive policy group and as a work group leader; and in Hawaii, Maryland, and Rhode Island, legislators were members of work groups.

3.1.3 Leadership

The states assigned leadership for developing their SIM Initiative Plan to a state employee within the Governor’s or Lieutenant Governor’s Office (Hawaii, Illinois, Iowa, Ohio, Rhode Island, and Utah), the state Medicaid agency (Colorado, Tennessee, and Texas), or the state’s department of health or other health-focused agency (California, Connecticut, Idaho, Maryland, Michigan, New Hampshire, New York, Pennsylvania, and Washington). In Delaware, the planning process was led by the Delaware Health Care Commission, a public private policy setting body with responsibility for several health care programs and initiatives

within the state. The SIM leadership often had a core team or executive committee made up of heads of major health departments within the state to assist in oversight and decision making. Several states also had advisory groups of public and private stakeholders to advise the SIM leadership team.

Stakeholders frequently noted the leadership of state agency staff—and consultant groups hired to assist with the planning process—as an important factor that influenced the planning process and its results. When state agency staff led the process, some stakeholders voiced concerns about those staff members’ capacity to focus on Plan development along with day-to-day agency management responsibilities. In general, state staff able to invest time in communicating with stakeholders were viewed most favorably; this was true, for example, in the five states where the SIM Initiative was located in the Governor’s or Lieutenant Governor’s Office and state leadership had no day-to-day agency management responsibilities.

3.1.4 Consultants and Contractors

The state SIM leadership frequently contracted with an external consulting group to augment staff resources needed to convene multi-stakeholder meetings, communicate to a broad array of stakeholders, conduct research, and contribute to drafting the Plan. In most states, consultants or contractor staff served as neutral facilitators in work groups and sometimes brought their own expertise to inform the stakeholders participating in the planning process. By having outside consultants and contractors manage the logistics of stakeholder forums and work group meetings, state staff members were able to use their time to prepare for substantive discussions.

Many states also hired additional consultants and outside contractors to provide specialized analyses that complemented state agency staff capabilities, such as financial or actuarial modeling, or services, such as conducting focus groups. Two states had numerous consultants working on the project (nine in one case, 12 in another); but most other states had two or three additional consultants contributing to the process, most of which were companies based in the state with knowledge of the state health care environment.

3.1.5 Planning Process and Structure

Most states had a formal work group structure. Work groups typically included public and private sector stakeholders and were charged with developing Plan proposals over the course of the planning period. In most states, the SIM leadership recruited individuals to join new work groups for the short-term assignment of Plan development, rather than engaging existing commissions or coalitions to develop the Plan. The number of work groups in each state ranged from zero to eight. Work groups were organized around stakeholder groups, model types, or specific issues, such as redesigning the delivery system; payment reform; health IT; data analytics; workforce issues; health equity; population health; integration of long term services

and supports (LTSS), behavioral health, or public health; and clinical quality. Seven states also had Steering Committees that served as clearing houses for the recommendations, aligned conflicting recommendations, and established priorities, as necessary.

All states had formal channels for communication, such as public meetings, Web site comments, and focus groups through which stakeholders could provide input. However, many stakeholders noted that one-on-one meetings between state officials (or their consultants) and stakeholders, in addition to work groups and other dedicated opportunities for providing input, were essential to developing ideas in their Plans and seeking support from various entities. These informal channels occurred during the process of developing the application for the SIM Initiative award, during the planning process, and after the formal work group meetings ended as SIM Initiative leads were making decisions on what to include in the final Plan.

3.1.6 Breadth and Method of Stakeholder Engagement

Most states involved the key health care stakeholders in their SIM planning process, including: state agencies (Medicaid, public health, human services, aging, insurance regulators, state-based marketplace), commercial health plans, hospital associations or key hospitals, medical societies, academic medical centers, clinicians, and consumer advocates. Most states did not include large self-insured employers in the plan development process, which was viewed as a major omission by some stakeholders. However, many states expanded the types of stakeholders engaged to include more clinical specialties, such as pediatricians and behavioral health care providers, and individuals with an understanding of the social determinants of health, such as public health officials and advocates, health equity experts, and advocates for persons with developmental disabilities.

The degree to which states engaged consumers or their representatives also varied. Some states used focus groups, town hall-style meetings, and Web-based comment boxes to solicit feedback. These strategies for consumer engagement are generally one way from the consumer to the planners; they do not have a clear feedback loop to reengage consumers. Connecticut, which added independent consumer representatives to its Steering Committee partway through the planning process, provides one of the few examples of states incorporating consumers in a bidirectional deliberation.

Several states cited difficulty engaging commercial payer stakeholders. The SIM Model Design planning process identified barriers to participation among the payer community. First, national health insurance carriers may be reluctant to adopt or align with state-specific quality measures and payment models rather than use their own company-wide quality measures and payment arrangements. Second, the latitude that commercial payers have in imposing new payment models on providers is constrained by contracts they currently hold with employers and providers. Nevertheless, examples of strong multi-payer alignment have occurred in some states

on other initiatives. In addition some states, such as Ohio, employed a planning framework that enabled greater payer participation than in others.

The states varied, however, with regard to how they recruited stakeholders to participate in the planning process, the level of input stakeholders had at different points in the planning process, and the willingness of SIM leaders to modify their planning structure to accommodate new ideas. For example, six states—Connecticut, Delaware, Hawaii, New Hampshire, Rhode Island, and Texas—had a completely open and inclusive planning process by design. Texas held open meetings to generate ideas for its Plan. In six other states, the SIM Initiative leaders established work groups and announced work group meetings publicly; all who attended could contribute their thoughts, even though the state also recruited key stakeholders to ensure their attendance and participation.

In contrast, most of the remaining states limited participation in Plan development in some way. For example, in Ohio, the state team leaders limited the core team to the five largest commercial insurers, Medicaid, and the state employees' health insurance plan. By focusing on payers, stakeholders in Ohio expressed confidence that payers had committed to some degree of alignment around the delivery and payment system models in the Ohio Plan; in part, this was attributed to development of a framework that encouraged payers to define which elements of these models should be standardized across payers, which should be aligned, and which would differ by design.

Most states that limited stakeholder participation conducted parallel outreach to the public through listening sessions around the state, solicitations for public comment, public presentations (in person or Web based), or email. In some of these states, enough people received early drafts or were adequately aware of the process to enable them to advocate for changes even if the initial components of the Plan were developed in closed-membership work groups. For example, in Connecticut, a number of stakeholders concerned about health equity pressed their case for certain models and strategies to be included in the state's Plan; in Iowa, pediatric providers voiced concerns during public forums that made the SIM Plan authors aware of the inadequacy of the selected quality measures for pediatric settings; and in Illinois, advocacy from a combination of public health advocates in the community and senior staff at the Illinois Department of Public Health resulted in the addition of a Population Health Task Force to the planning structure and additional public health-related enabling strategies in the state's Plan.

Many states included representation from public health in the planning process—either on their own recognition of the need, on advice from CMS, or as in Illinois, at the request of their other included stakeholders. In Maryland, stakeholders commented that this was the first effort where public health and community stakeholders had been invited to the table as an equal partner with health care payers and providers; the Maryland Plan proposed a model that significantly integrates community and health care resources to promote population health.

3.1.7 Timing of Stakeholder Input

The brief SIM Model Design/Pre-Test planning period demanded that most formal stakeholder input occur during several months in which work groups met frequently. Some stakeholders noted that the intensity of the planning process made it difficult for them to participate actively when they had to balance responsibilities within their home organizations. In some states, certain stakeholders had to manage the time they spent on the SIM Initiative with time spent advising on related initiatives, such as Medicaid expansion, Medicaid section 1115 waivers, and the launch of the state's health insurance marketplace, or with the concurrent legislative session. As a result, some stakeholders expressed concern about whether these competing priorities meant that some organizations or individuals who would have had valuable input opted out of participating.

Additionally, in many states, SIM leaders managed the short planning period by presenting initial proposals to kickstart discussions. In some cases, stakeholders viewed this approach as constraining and not very collaborative, while in other cases this approach was acknowledged as the only feasible way to get the task of developing a Plan done within the allotted time. To solicit public comment in the short time frame, some states posted draft versions of their Plan on a public Web site, and others circulated drafts by email. In other states, only the Innovation Center and the SIM initiative evaluators received the final Plan.

Finally, the short time frame for planning exacerbated other challenges faced by the states. For example, one state had turnover in SIM leadership, which resulted in a somewhat compressed time frame for planning.

3.1.8 Outcomes of the Planning Process

At the end of the Model Design period, each state submitted a final Plan that adhered to the general outline requested by the Innovation Center. States' SIM leaderships varied as to how they decided the final Plan content. Some states vetted their Plan with an existing advisory group of cabinet-level state officials; some used a consensus or voting process within groups of public and private stakeholders; and in others, SIM leadership was responsible for finalizing the Plan after formally or informally consulting with various stakeholders.

In most states, nongovernment stakeholders in each state (as of fall of 2013, when we spoke with them) were positive about the inclusiveness of the process and the ideas generated during discussions. However, many nongovernment stakeholders—especially insurance companies—noted that they could not comment on the likelihood of Plan implementation generally or firmly commit their organization to aligning with activities in the state without knowing more details. Most state government and nongovernment stakeholders also noted the importance of additional funding for realizing all of the components of their state's Plan.

3.2 Overview of Models and Strategies

The states took differing approaches to addressing the SIM Initiative aims of better health care, lower health care costs, and improved population health. Some states focused on primary care practice transformation to patient-centered, coordinated care; others focused on the integration of primary care providers and providers of acute care, behavioral health services, or LTSS, or the integration between the health and social services. Most of the models proposed by states included some form of payment reform, moving from a volume-based payment system to a value-based one, often in a phased-in approach with providers taking on more risk over time. In some states, adoption of value-based purchasing is the main focus and no single delivery system model is favored over another. Many state Plans had multiple foci, and all included enabling strategies designed to facilitate, promote, and sustain the health system transformation envisioned in the proposed models.

All states included one or more of four major delivery system and payment models in their Plans: (1) patient-centered medical homes (PCMHs), (2) health homes for medically complex populations, (3) integrated or accountable care systems, and (4) episode of care (EOC) payment models. *Table 3-1* shows the states that included these models. A glossary of terms can be found in the front matter.

PCMHs are included as part of 13 states' Plans. PCMHs provide whole person-oriented care that meets most of a patient's physical and mental health care needs and is delivered in the context of coordinated, team-led care. Primary care transformation to PCMHs is the centerpiece of the Plans for Connecticut, Hawaii, Idaho, Maryland, New York, Ohio, Rhode Island, and Texas. In the Colorado, Illinois, and Michigan Plans, primary care PCMHs are the foundation of integrated care systems, such as accountable care organizations (ACOs); and in the Pennsylvania and Tennessee Plans, they are one of several models being promoted for the states' transformation to value-based purchasing. Health homes, a variant of PCMHs that are geared toward medically complex patient populations and the providers serving them, are core models in the California, Colorado, New Hampshire, and Texas Plans.

Eight states' Plans have an "accountable care" component in which groups of provider—including physicians, hospitals, and other health practitioners—come together to work collaboratively and accept accountability for the cost of care for a defined set of patients. Accountable care models are the cornerstone of efforts to move to integrated, value-based care in Colorado, Delaware, Illinois, Iowa, Michigan, and Washington, whereas in Pennsylvania and Utah, accountable care models are only one of multiple models the state is promoting to achieve value-based purchasing.

Table 3-1. SIM Model Design and Pre-Test states and proposed health care delivery system models

| State | Patient-Centered | | Accountable | |
|---------------|------------------|-------------|-------------|-----------------|
| | Medical Home | Health Home | Care | Episode of Care |
| California | — | X | — | — |
| Colorado* | X | X | X | — |
| Connecticut | X | — | — | — |
| Delaware | — | — | X | — |
| Hawaii | X | — | — | — |
| Idaho | X | — | — | — |
| Illinois | X | — | X | — |
| Iowa | — | — | X | — |
| Maryland | X | — | — | — |
| Michigan | X | — | X | — |
| New Hampshire | — | X | — | — |
| New York* | X | — | — | — |
| Ohio | X | — | — | X |
| Pennsylvania | X | — | X | X |
| Rhode Island | X | — | — | — |
| Tennessee | X | — | — | X |
| Texas | X | X | — | — |
| Utah | — | — | X | — |
| Washington* | — | — | X | — |

NOTE: For category definitions, please see Glossary in the front matter.

* Indicates Pre-Test state.

X Indicates model is proposed in state Plan.

Three states—Ohio, Pennsylvania, and Tennessee—proposed EOC payment models. In these models, either a designated provider receives a prospective payment for a specific illness or course of treatment or total expenditures across participating providers are retrospectively reconciled to a target price. In all three states’ Plans, the EOC models were only one of multiple delivery system and payment models proposed.

In addition to the delivery system and payment models defined above, many states’ Plans included additional delivery system enhancements focused on a particular dimensions, such as expansion of behavioral health services or LTSS, integration of these services with the physical

health services, or care for special population groups (such as pregnant women, individuals at the end of life, and medically or socially complex patients).

States also proposed a variety of enabling strategies to promote, build, or transform the infrastructure that supports health care delivery and payment or enhances their effectiveness. Some of these enabling strategies followed from the guidance the Innovation Center gave to states about the content of the Plan; these include workforce development, health information technology (health IT) and data infrastructure, and the coordination with or integration of public health approaches. Two other enabling strategies emerged from the planning process: (1) development of organizations or policies to support providers’ adoption of new delivery and payment system models, and (2) mechanisms for engaging consumers in their health and health care. *Table 3-2* shows the states that included these strategies in their Plans.

Table 3-2. Enabling strategies proposed in each Model Design and Pre-Test state

| States | Workforce Development | Health IT Infrastructure | Data Aggregation and Analytics | Public Health Approaches | Infrastructure to Support Delivery System Transformation | Consumer Engagement |
|---------------|-----------------------|--------------------------|--------------------------------|--------------------------|--|---------------------|
| California | X | X | X | X | X | — |
| Colorado* | X | X | X | — | X | — |
| Connecticut | X | X | X | X | X | X |
| Delaware | X | X | X | X | X | — |
| Hawaii | X | X | X | — | X | X |
| Idaho | X | X | X | X | X | — |
| Illinois | X | X | X | X | X | — |
| Iowa | X | X | — | X | — | X |
| Maryland | X | X | X | X | X | — |
| Michigan | X | X | X | X | X | — |
| New Hampshire | X | X | — | — | — | X |
| New York* | X | X | X | X | X | X |
| Ohio | X | X | X | — | — | — |
| Pennsylvania | X | X | X | X | X | — |
| Rhode Island | X | X | X | X | X | X |
| Tennessee | X | X | X | — | — | — |
| Texas | X | X | X | X | X | — |
| Utah | X | X | X | X | — | X |
| Washington* | X | X | X | X | X | — |

NOTE: For category definitions, please see Glossary in the front matter.

* Indicates Pre-Test state.

X Indicates model is proposed in state Plan.

All Model Design and Pre-Test states proposed new workforce development strategies in their Plans to enhance the existing health care workforce and add roles and responsibilities or professional categories not previously considered as part of the clinical workforce, such as

community health workers or mental health peer counselors. In addition, some states proposed new policies and programs that would: develop data systems for forecasting future health care workforce needs, address workforce training needs, redistribute the workforce within a state, or change scope-of-practice laws or licensing requirements.

All Model Design and Pre-Test states also proposed a health IT strategy to develop or enhance systems that maintain and transmit individually identifiable clinical data, or promote the use of such systems. The systems include electronic health records (EHRs) and health information exchanges (HIEs) for transmitting health information among providers. Health IT strategies also include promoting providers' use of secure messaging (email) with patients and encouraging patient access to their own health information through secure Web portals maintained by providers or other entities. Complementing health IT strategies, states also proposed a data aggregation and analytics strategy. Seventeen states proposed the development or enhancement of systems to maintain clinical, utilization, and expenditure data—such as All Payer Claims Databases (APCDs), data aggregation and analytic capabilities, the production of population-level quality and cost information, and public reporting of these data.

Transformation to patient-centered care requires broadening the focus of health professionals and health care institutions beyond treating illness to helping people lead healthy lives. To achieve this, 14 states included public health strategies in their Plans. Public health strategies are typically delivered outside the health care delivery system to the general population. Often, a non-health care provider is responsible for promoting public health strategies, and in some cases is the backbone organization to a defined coalition for health or accountable community for health. Common goals of public health strategies are to improve heart health, tobacco cessation, and to reduce obesity. These strategies include community-based activities or closer relationships between clinical health care providers and non-health care organizations—such as social services, schools, community development organizations, transportation, parks and recreation agencies, and civic groups.

Infrastructure to support delivery system transformation organizations, as proposed by 13 states, includes organizations and policies that support technical assistance to practitioners within the health care delivery system. The focus of this assistance may be on the transition to a medical home, adoption of team-based care, improvement on certain health or cost outcome aims, integration with community resources, and readiness to participate in value-based payment models.

Consumer engagement strategies, proposed explicitly in seven state Plans, describe activities intended to change consumer/patient behavior directly. These activities include promoting patient-centered communication; changing the clinical setting to activate patients in their own care, including access to their own health information; and promoting choice

architecture within insurance plans to help consumers choose the highest-value health care services (e.g., value-based insurance design).

3.3 Patient-centered Medical Home and Health Home Models

Health care delivery models for providing whole person-oriented care that meets most of a patient’s physical and mental health care needs and is delivered in the context of coordinated, team-led care can be described using various terms. The terms “medical home,” “patient-centered medical home,” or “health home” are often used synonymously for referring to these kinds of models. However, the term “health home” can also refer to a specific model of care authorized for Medicaid beneficiaries by Section 2703 of the ACA. In this section, we provide definitions for PCMH and health home models and discuss how states proposed to incorporate, spread, or enhance these kinds of models within their Plans.

PCMH models. The PCMH originated as a practice philosophy for providing *comprehensive primary care services* to children and adults. The primary care medical professional societies endorsed a joint statement in 2007 articulating principles of a PCMH approach (American Academy of Family Physicians, 2007). *Table 3-3* describes the five core PCMH functions as defined by the Agency for Healthcare Research and Quality (AHRQ) that evolved from the principles endorsed in the joint statement (AHRQ, 2014). In addition to these core functions, three enabling attributes (health IT, workforce development, and payment models) provide the supporting structure for primary care practices to reorganize practice systems and processes and establish linkages with the medical neighborhood (e.g., hospitals, specialists) to fully realize the vision of the model.

Table 3-3. PCMH functions and attributes

Comprehensive primary care that meets the majority of a person’s physical and mental health needs, including preventive, chronic, and acute care.

Patient-centered care oriented to the whole person.

Coordinated care across different settings, specialists, and the community.

Accessible care for urgent and routine needs using a variety of modalities, including in-person, telephone, and electronic access.

Practice commitment to quality and safety through participation in quality improvement activities and patient experience measurement, use of evidence-based practices and clinical decision support tools, and population health management.

Enabling attributes: health IT, workforce development, payment models.

Source: AHRQ, 2014.

Although the PCMH core functions are useful for articulating the PCMH vision for primary care practice, accrediting organizations, researchers, policy makers, and payers have

developed more granular criteria for specifying primary care practice policies, processes, or infrastructure that distinguish a practice as a PCMH. All PCMH payment models require participating practices to be recognized as a PCMH; however, nationally, numerous different sets of standards exist for practice recognition as a PCMH. The National Committee for Quality Assurance (NCQA) is one of the most commonly used PCMH recognition programs, having issued its first set of PCMH standards in 2008. Payers, including state Medicaid agencies, may also establish their own practice PCMH criteria, which may or may not rely on external recognition from an organization such as NCQA.

Payment models to support PCMH can vary. A common model is for payers to provide a modest, monthly per member per month (PMPM) payment or use an enhanced fee schedule to cover care coordination services that would not otherwise be reimbursable in a fee-for-service (FFS) model. In some PCMH payment models, periodic lump sum payments are made to support practice transformation activities—for example, investments in health IT or for system-level changes needed to achieve higher levels of PCMH functionality. Some PCMH models include payments for meeting quality measure targets; payments for meeting quality measure AND cost targets (i.e., shared savings models); and comprehensive, risk-adjusted PMPM payments with additional payments for meeting quality measure targets. These PCMH payment models are less feasible for small practices, because these practices often lack sufficient numbers of patients to provide reliable estimates for quality measures.

In the years leading up to the awards, a proliferation of PCMH pilot programs and demonstrations projects occurred. This included numerous statewide or regional single commercial payer or Medicaid PCMH programs, some statewide or regional multi-payer PCMH programs, and several federal initiatives. The federal initiatives include the Comprehensive Primary Care Initiative, the Federally Qualified Health Center (FQHC) Advanced Primary Care Demonstration, and the Multipayer Advanced Primary Care Practice Demonstration, in which Medicare joined existing multi-payer PCMH programs within eight states. *Table 3-4* summarizes existing PCMH programs across the Model Design and Pre-Test states.

Health home models. Health homes as defined in this report are a variant of PCMHs located at a primary care practice or other type of provider practice. Health homes offer patients—usually those with medically or socially complex conditions—person-centered care and facilitate access and coordination across primary care and providers of mental health, substance abuse services, long term supports and services (LTSS), and other specialists.

Table 3-4. Existing state PCMH and Section 2703 Health Home initiatives and PCMH components in the state’s Plan

| | Number of FQHC Advanced Primary Care Demonstrations | Number of Comprehensive Primary Care Initiative Sites | Medicaid PCMH Program | Current Multi- payer PCMH Programs | State Plan Amendment(s) for Sec 2703 Health Homes (approved as of 10/1/2013) ^a |
|---------------|--|--|-----------------------------|--|---|
| California | 68 | — | — | — | — |
| Colorado* | 10 | Statewide (74 practices) | X ^b | — | — |
| Connecticut | 1 | — | X | — | — |
| Delaware | — | — | — | — | — |
| Hawaii | 4 | — | X | — | — |
| Idaho | 5 | — | X ^c | X | X |
| Illinois | 23 | — | X ^d | — | — |
| Iowa | 5 | — | X | — | X |
| Maryland | 7 | — | X ^e | X | X |
| Michigan | 14 | — | X ^e | X ^f | — |
| New Hampshire | 12 | — | — | — | — |
| New York* | 20 | Regional (74 practices) | X | X ^f | X |
| Ohio | 20 | Regional (61 practices) | X ^e | — | X |
| Pennsylvania | 15 | — | X ^e | X ^f | — |
| Rhode Island | 3 | — | X ^g | X ^f | X |
| Tennessee | 12 | — | X ^h | — | — |
| Texas | 3 | — | — | — | — |
| Utah | — | — | — | — | — |
| Washington* | 16 | — | X ^e | X | X |

* Indicates Pre-Test state.

X Indicates initiative is present in the state.

^a Source <http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/State-by-State-HH-SPA-matrix-6-15-12.pdf> .

^b Program is limited to Medical Homes for Children.

^c Medicaid participates in the multi-payer PCMH program through a state plan amendment for Section 2703 Health Homes.

^d Offers enhanced payments for practices participating in state’s primary care case management program, but is not explicitly referred to as a PCMH program.

^e Medicaid participates in the multi-payer PCMH program.

^f Medicare participates in this multi-payer program through the Multipayer Advanced Primary Care Practice Demonstration.

^g A Medicaid section 1115 waiver requires that all Medicaid beneficiaries receive care from a PCMH.

^h Some Medicaid MCOs have single-payer PCMH programs, Medicaid FFS does not have a PCMH Program.

Abbreviations: FFS = fee for service, FQHC = federally qualified health center, MCO = managed care organization, PCMH = patient-centered medical home.

Section 2703 of the ACA gave states the statutory authority to provide health homes for Medicaid enrollees with chronic conditions through an SPA to the Medicaid State Plan. The approach and guidance for health home definition and implementation was built on existing state and federal experience with PCMH, but also draws on additional state and federal experience related to primary care and behavioral health integration, delivery systems other than traditional primary care that focus on high-use and high-cost beneficiaries, and LTSS across the lifespan. SPAs that define Section 2703 Health Homes require specification of the target population for the health home, services provided within the health home, health home provider infrastructure and standards, and payment specifications. As of October 1, 2013, 15 states have a Health Home SPA, including seven Model Design or Pre-Test states (Idaho, Iowa, Maryland, New York, Ohio, Rhode Island, Washington). *Table 3-4* indicates states with Section 2703 Health Home SPAs approved and in effect as of October 1, 2013. *Table 3-5* provides additional detail about the approved Section 2703 Health Home SPAs in Model Design and Pre-Test states.

Table 3-5. Details of current Section 2703 Health Home initiatives in Model Design and Pre-Test states (approved as of 10/1/2013)^a

| State | Scope | Providers | Population |
|--------------|---|--|---|
| Idaho | Statewide | Physicians, medical practices, rural clinics, community health centers, CMHCs, home health agencies, or any existing Medicaid primary care case management providers | Individuals with SED or SPMI, DM, or asthma and at risk for another condition |
| Iowa | Statewide | Primary care practices, CMHCs, FQHCs, and rural health centers | Individuals with multiple chronic conditions including hypertension |
| | Regional | Lead entity and qualified integrated health home providers | Individuals with SPMI |
| Maryland | Statewide | Psychiatric rehabilitation programs, mobile treatment service providers, opioid treatment programs | Opioid substance use disorder plus risk of another chronic condition, or SPMI |
| Ohio | Initially regional with goal of statewide | CBHCs | Individuals with SPMI |
| Rhode Island | Statewide | Family centers providing services to children with special health care needs | SPMI or SED, two chronic conditions (mental health, asthma, diabetes, developmental delay, Down syndrome, mental retardation, seizure disorder) or one and risk for another |
| | Statewide | CMHCs and two smaller providers of specialty mental health services | Individuals with SPMI eligible for state's community support program |
| | Statewide | Opioid treatment programs | Individuals with opioid dependence |
| New York* | Statewide | Any interested providers meeting criteria | Individuals with SPMI or chronic medical and behavioral health conditions |
| | Regional | | |

(continued)

Table 3-5. Details of current Section 2703 Health Home initiatives in Model Design and Pre-Test states (approved as of 10/1/2013)^a

| State | Scope | Providers | Population |
|-------------|----------|--|---|
| Washington* | Regional | Medical practices, community health centers, CMHCs, home health agencies, case management agencies, FQHCs, hospitals, MCOs, primary care case management providers, substance use disorder treatment providers | Individuals with one chronic condition and risk of developing another (includes both physical and mental health conditions) |

* Indicates Pre-Test state.

^a Source <http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/State-by-State-HH-SPA-matrix-6-15-12.pdf>.

Abbreviations: CBHC = community behavioral health center, CMHC = community mental health center, DM = diabetes mellitus, FQHC = federally qualified health center, MCO = managed care organization, SED = seriously emotionally disturbed, SPA = state plan amendment, SPMI = serious and persistent mental illness.

PCMH and health home models share a similar underlying philosophy of coordinated, whole person-oriented care. PCMH models are typically for practitioner-led, team-based primary care without regard to any specific patient population, whereas health homes are typically focused on medically or socially complex patients. Section 2703-defined Health Homes are specific to segments of the Medicaid population, and to the types of Medicaid providers authorized by the state’s Health Home SPA, which can include providers other than primary care providers. In some states, the Health Home SPA is narrowly defined for individuals with substance use disorders or serious and persistent mental illness and associated mental health treatment providers. In other states, the Health Home SPA defines its health home more broadly and in alignment with the existing state PCMH criteria such that medical practices recognized as PCMHs may also qualify as Section 2703 Health Homes. Thus, states have options for offering coordinated, whole person-oriented care to Medicaid beneficiaries, including through a Medicaid-specific or multi-payer PCMH program or a Section 2703 Health Home SPA. These two options are not mutually exclusive; states can use both strategies depending on their goals and on the existing health care delivery and payment landscape.

3.3.1 Variations in Proposed PCMH and Health Home Models

Plans in 15 states proposed changes to their delivery system that would increase patient access to PCMHs or Section 2703 Health Homes or both. These include California, Colorado, Connecticut, Hawaii, Idaho, Illinois, Maryland, Michigan, New Hampshire, New York, Ohio, Pennsylvania, Rhode Island, Tennessee, and Texas. State experience with these models was a significant factor as to whether a PCMH or Section 2703 Health Home component was included in the state’s Plan.

The Plans vary with respect to design of the PCMH or Section 2703 Health Home model, scope of implementation, and stage of readiness for implementation. For example, the medical home component of the Texas Plan—which includes PCMH, Section 2703 Health Homes, and maternity homes—is the main health care delivery innovation in the state Plan but involves mostly PCMH transformation support for practices and a plan for collaboration to define future multi-payer infrastructure and payment models. Details regarding Section 2703 Health Home implementation were not provided. In contrast, statewide adoption of PCMH models was the single, main innovation model proposed in the Plans from Connecticut, Hawaii, Idaho, Maryland, New York, and Rhode Island. In these states, the Plans aimed to have 80 percent or more of their respective populations receiving care in PCMH practices by the end of a Model Test period.

In seven states (California, Colorado, Michigan, New Hampshire, Ohio, Pennsylvania, and Tennessee), PCMH models or Section 2703 Health Homes or both are one of several proposed delivery innovations in the states' Plans. For example, California's draft Plan proposed creation of "health homes for complex patients" based on a PCMH-style model as one of four major initiatives. However, the state did not clearly express whether this strategy would be limited to Section 2703 Health Homes, or would also include expansion of PCMH models. In Colorado and Michigan, which both have significant numbers of practices already recognized as PCMH practices and participating in multi-payer PCMH programs, statewide PCMH expansion and further development of PCMH capabilities would be the foundation for ACO development and expansion. In Illinois, PCMHs would be part of the entities that form under the proposed accountable care models. Ohio, Tennessee, and Pennsylvania proposed payments for episodes of care in addition to PCMH models, as a mutually reinforcing approach to systemwide movement to value-based payment. Although New Hampshire's Plan included mention of health homes, this does not appear to be as integral to its Plan as in the other states and was not discussed in any significant way by stakeholders.

Although the core PCMH models states proposed are similar, some states designed special areas of focus or unique aspects for their PCMH model. In some cases, states would use Section 2703 Health Homes as a complementary strategy for further expansion of PCMH models throughout the state, in other states the role of Section 2703 is less clear. The PCMH special emphasis areas and the role of Section 2703 Health Homes in primary care practice transformation are listed in [Table 3-6](#).

Criteria for PCMH practice recognition. Unlike Section 2703 Health Homes, which are statutorily defined, no single standard or criterion exists for practice recognition as a PCMH. As a result, existing single-payer, multi-payer, and Medicaid PCMH programs use varied criteria. NCQA is a commonly used recognition program, although existing state or payer PCMH programs sometimes include additional requirements or use different criteria in lieu of

formal NCQA recognition. A common theme among states was concern about the financial and administrative burden that obtaining external PCMH recognition imposes on practices—leaving little bandwidth for actual practice transformation—and a concern over unnecessary administrative burden of additional recognition requirements on practices already formally recognized as PCMH practices.

Table 3-6. Model Design and Pre-Test states with PCMH or Health Home models

| State | PCMH Special Emphasis Area | Role of Section 2703 Health Homes in Primary Care Practice Transformation |
|---------------|--|---|
| California | Palliative care | Unclear, but expects criteria developed for PCMHs to meet requirements for Section 2703 Health Homes. |
| Connecticut | No special emphasis | Will not use as a primary care practice strategy, but anticipates that 15% of the Department of Mental Health and Addiction Services (DMHAS) population will be dually attributed to a PCMH and DMHAS’s Health Home Model, which is scheduled for 2014 implementation. |
| Colorado* | Behavioral health integration in primary care | Will use for community-based mental health centers to qualify as PCMHs. |
| Hawaii | Behavioral health integration in primary care, including use of telehealth for increased access to behavioral health providers | Will use to develop PCMHs with expanded capabilities for Medicaid recipients with SPMI, SED, or with two or more of the following: diabetes, heart disease, obesity, chronic obstructive pulmonary disease, and substance abuse. |
| Idaho | Will use telehealth to create virtual PCMHs and expand PCMH care team to include CHWs and EMS personnel. Will also focus on integration of behavioral health into primary care | Is currently being used to enable the state’s Medicaid program to participate in the existing multi-payer PCMH program and the state will continue to use it in this way, and will pay PMPM for Medicaid beneficiaries who do not meet health home criteria. |
| Illinois | The Integrated Delivery Systems would be built around PCMHs | Not mentioned |
| Maryland | Establishes community-integrated medical homes that have close linkages with community health hubs that can provide targeted community-based interventions to selected high-risk populations | PCMH recognition criteria will include health home designation as one of the available criteria for recognition. |
| Michigan | No special emphasis | Will develop a Health Homes pilot to provide comprehensive care coordination for beneficiaries with a serious and persistent mental health condition who also have co-occurring chronic medical conditions and high rates of hospital and emergency department utilization. |
| New Hampshire | Not applicable; state is not proposing PCMH model | Will use as part of strategy for LTSS delivery reform. |

(continued)

Table 3-6. Model Design and Pre-Test states with PCMH or Health Home models (continued)

| State | PCMH Special Emphasis Area | Role of Section 2703 Health Homes in Primary Care Practice Transformation |
|--------------|---|---|
| New York* | Includes several tiers of PCMH, with the most advanced including integration of behavioral health within primary care | Considers health homes as a complementary strategy for providing integrated care to 80% of the state’s population, particularly to those with specialized needs. Will continue to support these models as part of its overall strategy. |
| Ohio | No special emphasis. | Will use to complement PCMH model and continue to support and identify linkages between health homes and PCMH. |
| Pennsylvania | Includes option for behavioral health providers to become PCMHs if they are willing to assume responsibility for physical health either directly or in partnership with other health care providers Proposes establishment of care management teams to augment services provided by PCMHs for Medicaid patients with complex needs | Not mentioned. |
| Rhode Island | Expands PCMH to pediatric practices and involves medical specialists and hospitals as a medical neighborhood Will establish community health teams to support PCMH practice transformation and care coordination | Unclear what role these will play. |
| Tennessee | No special area of emphasis | Not mentioned. |
| Texas | No special area of emphasis; focus of Plan is on training and support for practices to achieve PCMH recognition | Proposes to support training and assistance for health homes, similar to activities planned for PCMH support. |

* Indicates Pre-Test state.

Abbreviations: CHW = community health worker, EMS = emergency medical system, LTSS = long-term services and supports, PCMH = patient-centered medical home, SED = seriously emotionally disturbed, SPMI = serious and persistent mental illness.

States can be grouped into two categories with respect to how their Plans defined the criteria for practices to become recognized as PCMH practices. California, Connecticut, Idaho, Ohio, and Tennessee deferred development of PCMH recognition criteria to a future task force or work group. In contrast, Colorado, Hawaii, Maryland, Michigan, New York, Pennsylvania, and Rhode Island would use previously identified PCMH recognition criteria, with some states offering refinements to these criteria as part of their SIM plan. For example, Rhode Island’s Plan implied (but did not specify) that it would continue using NCQA standards as it does currently for at least a couple of its existing PCMH initiatives, including Chronic Care Sustainability Initiative-Rhode Island (CSI-RI). Some states concerned about the practice burden involved in seeking formal recognition proposed minimum initial standards to get practices started down the

path toward practice transformation. States taking this approach also proposed PCMH payment models designed to incentivize continued transformation. *Table 3-7* summarizes the criteria for PCMH practice recognition among the states with specific criteria in their Plans.

Table 3-7. Comparison of PCMH recognition criteria proposed in Plans

| State | PCMH Recognition Criteria |
|--------------|--|
| Colorado* | Will not require formal external PCMH recognition, but has established competencies related to comprehensive primary care that will be evaluated periodically using the Comprehensive Primary Care Practice Monitor Tool. |
| Hawaii | NCQA Level 1 Recognition (2011 Standards) -OR- alternative path for practices to meet minimum criteria without formal NCQA recognition. Long-term goal is for practices to achieve Level 3 NCQA recognition. |
| Maryland | <ul style="list-style-type: none"> • Any of the following: <ul style="list-style-type: none"> — Recognition as a PCMH through an existing single or multi-payer PCMH program — Federally qualified health center advanced primary care practices — Section 2703 Health Homes — Practices associated with a Medicare ACO • For practices not meeting above criteria, the state defined the following minimal standards: <ul style="list-style-type: none"> — Use of statewide standard quality measures — Use the state’s HIE encounter notification system — Must accept both Medicaid and Medicare beneficiaries — Must collaborate with community health teams associated with community health hubs |
| Michigan | Designation as a PCMH through Blue Cross Blue Shield of Michigan -OR- NCQA Level 2 or 3. |
| New York* | Practices not yet meeting formal criteria can be certified as Pre-Advanced Primary Care Practices (APC), practices already meeting NCQA (any level) can be certified as standard APC, and practices with certified EHRs meeting Meaningful Use, with HIE interoperability, and that meet additional nonmandatory Level 3 NCQA criteria can be certified as “premium” APCs. |
| Pennsylvania | Must obtain recognition from an external, nationally recognized entity, such as NCQA or the Commission on Accreditation of Rehabilitation Facilities to be eligible for shared savings and to receive funding to establish a care management team through Medicaid MCOs. |
| Rhode Island | Plan not explicit about criteria, current initiative uses NCQA Recognition or recognition in Blue Cross Blue Shield Rhode Island proprietary PCMH. |

* Indicates Pre-Test state.

Abbreviations: ACO = accountable care organization, EHR = electronic health record, HIE = health information exchange, MCO = managed care organization, NCQA = National Committee for Quality Assurance, PCMH = patient-centered medical home.

Linkages to supporting community-based entities. Some state Plans specifically designed supporting community-based entities to partner with PCMH practices to provide care coordination, community-based services, and support for patients with complex medical, behavioral, or social issues. Idaho proposed use of community health workers (CHWs) and emergency medical system personnel to help provide team-based care in medically underserved areas. For example, they might work with PCMH practices to provide home follow-ups and reduce emergency room use. Maryland proposed creation of community health hubs to provide

community interventions by nurses and CHWs for selected targeted populations with disparities in health outcomes or who represent a disproportionate share of health care spending. Michigan proposed creation of community health innovation regions, which are consortia of cross-sector community organizations that would prioritize and champion evidence-based interventions. New York proposed creation of regional entities to convene shared resources for care coordination. Lastly, Rhode Island proposed formation of community health teams for care coordination and care management, both within and outside primary care practices, that would be specifically designed as a shared resource, particularly for smaller practices. The extent to which these state Plans detailed governance, payment models, and level of integration among the proposed community entities and practices varied.

PCMH payment models. The PCMH and Section 2703 Health Home payment models proposed by states are similar, although timelines for implementation differed—because some states would largely be continuing their existing models, while others would need to finalize details and put the data infrastructure into place before implementation. Most states proposed a model that gradually transitions practices from FFS to value-based payments; however, few proposed full transition to global budgets. FFS plus additional monthly PMPM for upfront support for care coordination and practice transformation is already in place in many states, so these states plan to gradually move payers and providers into pay-for-performance or shared savings arrangements, initially with upside-only risk. As practices demonstrate success within shared savings, some payers and providers may choose to move into models with both upside and downside risk. Most states would continue to allow payers to set their own payment levels and use their own attribution and risk adjustment methodology, although some states may establish guiding principles for these aspects, such as designing incentives to reward absolute more than relative performance. Some states proposed specific features about their PCMH payment model that note mention here: Medicaid in Connecticut would only participate in models with upside-only risk and Michigan would develop some innovative types of PCMH payment incentives, such as a continuity of care adjuster to incentivize care continuity for patients.

Commercial payer participation. All states proposing *statewide expansion* of PCMH models would rely on voluntary cooperation among commercial payers. States with existing PCMH programs would build on existing single or multi-payer commercial participation. Hawaii, which had an existing Medicaid PCMH model, secured commitment from all commercial payers during Plan development to reimburse a higher rate for providers recognized as NCQA PCMH Level 1 practices. In most states proposing PCMH models, stakeholders commented that payers are generally in agreement with the overall concept for PCMH but wanted more details before committing to participation. Depending on where the state was starting from, these details may not have had time to be worked out during the planning process. Lastly, stakeholders across many states expressed uncertainty about the prospects of voluntary

adoption among large, self-insured employers, particularly because the stakeholder representation of this group was minimal in most states' planning process.

3.3.2 Policy Levers

Many states would use their position as large health care purchasers to drive PCMH adoption, by requiring PCMH models in Medicaid managed care organization (MCO) contracts. This would require new or revised Medicaid section 1115 waivers in most states. For example, Michigan would request a section 1115 waiver and SPA to permanently incorporate the existing PCMH payments being made separately as part of its PCMH Demonstration, when the 2015 Demonstration results are available and the state makes the final decision to expand PCMH statewide. Although many states would encourage practices that serve Medicare FFS beneficiaries to adopt a PCMH model, most would not mandate this. In addition to state purchasing power for Medicaid, some states proposed to include requirements for PCMH models in state employee health plan contracts (e.g., Hawaii, Ohio, Pennsylvania). Ohio proposed to use the state's purchasing power to provide "leadership and cover" for the five commercial payers that participated in the planning process for them to renegotiate provider contracts to include PCMH models. Because a greater majority of patients are covered by the same payment and reporting model, Ohio would expect providers to ask the remaining payers to follow.

A few states would use legislation and regulation to facilitate multi-payer efforts. Maryland would introduce legislation in 2014 to reauthorize and expand its current state-led multi-payer PCMH program, which was scheduled to sunset at the end of 2014. Rhode Island would introduce legislation in 2014 to affirm its commitment to expand access to PCMH statewide by 2020 and contemplate the use of unique regulatory functions authorized by 2004 legislation to propose requirements for 80 percent of commercial payments in the small, large, and self-insured markets to be value based. Similarly, New York would consider changes to the process it uses to regulate health insurance products, specifically policy form approval, health maintenance organization licensure renewal, and premium rate review processes. New York would refine these processes such that payers would have the opportunity to report how their portfolio is distributed with respect to value-based payment models proposed for their three-tiered PCMH initiative.

In most states, stakeholders viewed state legislative or regulatory action as potentially disrupting existing PCMH programs and provider contracts; many requested that the states avoid using legislative mandates to achieve their vision during the course of the planning process. For example, stakeholders in Idaho contemplated legislation requiring major payers to participate in the model but in the end decided to foster voluntary provider and payer participation. Because voluntary participation was proposed for commercial payers in most states, many Plans proposed the state as the continued convener of further stakeholder discussions and multi-payer collaboration—for example, convening work groups to establish practice standards for PCMH

recognition or determine the payment model for multi-payer approaches. Some states with existing PCMH programs already function in this role. In other states, this would be a new role; for example, Tennessee developed a PCMH charter across payers to bring the various initiatives into alignment, and the state has asked payers to endorse the charter as part of implementing the proposed PCMH pilot.

As previously discussed, some states proposed Section 2703 Health Homes either alone or in addition to PCMH models. In addition to expanding the existing PCMH through voluntary action, Colorado would also pursue a Section 2703 SPA to integrate medical care into behavioral health settings for patients with serious mental illness. Similarly, Idaho would use its existing Section 2703 Health Home SPA and pursue a new SPA for Medicaid and CHIP participation in PCMH to complement voluntary action by providers and commercial payers. In contrast, California would rely primarily on Section 2703 Health Home authorizations to implement its vision for medical homes, a narrower scope than many of the other Model Design and Pre-Test state Plans for PCMH. Similarly, Texas proposed to support multiple efforts to expand the medical home concept—including efforts to support the many small and medium-sized practices in the state, as they take steps toward the medical home model by building on Delivery System Reform Incentive Pool projects under a Medicaid section 1115 waiver and prior quality, health IT, and medical home initiatives in the state. Lastly, New Hampshire was already planning to establish Section 2703 Health Homes as part of its transition to Medicaid managed care and would build on this approach by expanding on the eligibility definition for health homes to include individuals with LTSS needs.

3.3.3 Implementation

The details in state Plans regarding timeline for implementation of PCMH or Section 2703 Health Home models or both varied widely. The complexity of the infrastructure supporting the proposed PCMH model and the degree of model specificity achieved during the Plan development process are key determinants of implementation timeline. States with existing multi-payer PCMH programs (Colorado, Idaho, Maryland, New York, Ohio, Pennsylvania, Rhode Island) generally described implementation of the PCMH component of their Plan as an extension or expansion and most were poised to begin certain aspects of expansion in 2014. Michigan, which is host to one of the country's largest multi-payer PCMH demonstration, would not seek to continue its PCMH effort or expand it to additional payers until sometime after 2015, and only after considering the evaluation findings from the current demonstration. States targeting implementation of PCMH initially within the context of the state's Medicaid program cited the need to obtain new or revised section 1115 waivers or a Health Home SPA. Hawaii and Connecticut both already have Medicaid PCMH programs and commercial single-payer PCMH programs, but proposed statewide adoption of PCMH through new multi-payer models; thus, implementation would require states, payers, and providers to negotiate final multi-payer model details and put the data infrastructure into place to support the multi-payer model.

Nearly all states reported that a Round 2 Model Test award would be a major lever for implementing PCMH models, particularly for multi-payer PCMH programs. Most states would use a Model Test award to fund the work related to setting up or enhancing the data infrastructure and analytic capacity required for the PCMH payment model. Many states also proposed using a Model Test award to fund support for practice transformation by establishing central or regional entities that would provide practice transformation facilitation services. Some states proposed to use Model Test award funds to cover PCMH payments to providers (e.g., upfront PMPM care coordination payments, enhanced FFS payments, pay-for-quality incentives) during some of the Model Test period. Most state officials in most states reported that they would try to implement elements of their Plans even in the absence of a Round 2 Model Test award, but acknowledged that the scope and pace of implementation would be narrower and slower than with the award. Some states reported that they would not rely solely on a Round 2 Model Test award and would seek additional external funding for implementation.

A common theme we identified across the states proposing PCMH models is that although stakeholders considered the PCMH concept feasible, some expressed concerns about the absence of specific details in the Plan, lack of adequate funding to build or expand required support infrastructure, and competing priorities (e.g., Medicaid expansion, health insurance marketplace development) that will strain the state's capacity to implement. Most agreed that feasibility would be enhanced with dedicated implementation funding, but stakeholders in some states expressed lingering doubts about the willingness of some stakeholders—particularly national carriers, large self-insured employers, and payers in competitive markets—to go along with the Plan.

Some states noted specific barriers to implementation. For example, Colorado's existing capitated system for behavioral health reimbursement in Medicaid is a barrier to behavioral health and primary care integration. New York also cited existing licensing and regulatory barriers to behavioral health and primary care integration—for example, the sharing of certain types of patient health information related to behavioral health diagnosis and treatment. Stakeholders in two states, Pennsylvania and Rhode Island, identified the 2014 gubernatorial elections as potentially influencing implementation of the Plan overall, but this concern was not specific to the PCMH component. In Idaho, the state considers external funding mandatory to expand PCMH to rural areas, which are served mostly by small practices and would require enhanced telehealth capabilities and support for practice transformation to be successful. Similarly, Texas stakeholders noted the challenge of achieving formal PCMH recognition in small practices; thus, moving practices towards PCMH concepts is a goal of the Texas Plan, which was noted as being potentially more feasible than trying to achieve widespread formal PCMH recognition.

3.4 Accountable Care Models

The defining characteristics of an accountable care model are that a risk-bearing entity (e.g., set of providers) takes on some level of financial risk for a set of assigned patients regardless of where those patients receive their direct medical care, and assures some degree of quality care provided to its assigned population. Medicare defines its ACOs as “groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high-quality care to the Medicare patients they serve” (CMS, 2011). Other programs have defined ACOs to include health plans, too—for example, in Utah, the state Medicaid program contracted with MCOs to assume both financial risk and accountability for quality metrics for more than three quarters of the Medicaid population in the state (Anderson, 2013).

In this context, Plans in 8 of 19 Model Design/Pre-Test states (Colorado, Delaware, Illinois, Iowa, Michigan, Pennsylvania, Utah, and Washington) proposed developing new accountable care models or expanding existing models of risk-bearing entities that integrate care delivery for the population. In these states, the accountable care models that would be implemented are different—sometimes characterized as “more flexible,” sometimes more prescriptive—than the Medicare Shared Savings ACO model. Some of these states have branded their accountable entities with names to reflect differences from Medicare’s model: Regional Care Collaborative Organizations under the Accountable Care Collaborative (Colorado); Comprehensive, Community-Based Integrated Delivery Systems, including Accountable Care Entities and Care Coordination Entities (Illinois); Accountable Systems of Care (Michigan); Accountable Provider Organizations (Pennsylvania); and Accountable Risk-Bearing Entities (Washington). In addition, states such as Rhode Island and Utah proposed to promote value-based payment mechanisms that could include, but not be exclusive to, ACO development. Unlike Medicare ACOs, some states proposed an accountable care model that could include MCOs as the risk-bearing entity (Michigan, Utah, Washington). **Table 3-8** summarizes features from the eight states that proposed accountable care models, with regard to the existing ACO initiatives in the state, target population(s), and key features (if known) of the envisioned delivery system. This section compares the accountable care components of each state’s Plan and anticipated policy levers that would be used to support ACO implementation and challenges to implementation.

Table 3-8. Comparison of accountable care models across Model Design and Pre-Test states

| State | Existing Initiatives | Proposed Populations Served | Key Features of Proposed Accountable Care Model |
|-----------|---|--|--|
| Colorado* | <ul style="list-style-type: none"> Medicaid Accountable Care Collaborative Program, which funds seven Regional Care Collaborative Organizations Comprehensive Primary Care Initiative | <p>Medicaid enrollees statewide</p> <p>Commercial payer covered lives, if payers choose to participate</p> | <ul style="list-style-type: none"> Builds on existing definitions in Medicaid Regionally based entities Integrates behavioral health care into primary care setting Eventually integrate public health, oral health, long-term care, and social and community support services |
| Delaware | <ul style="list-style-type: none"> Commercial payer ACO contracts Medical Society ACO program | <p>Medicaid managed care organization enrollees</p> <p>Commercial payer covered lives, if payers choose to participate</p> | <ul style="list-style-type: none"> Can be either Medicare ACO definition or provider-defined organization that supports clinical integration and accountability for outcomes-based payment |
| Illinois | <ul style="list-style-type: none"> Commercial payer ACO contracts Medicare ACOs Medicaid FFS contracts with provider-driven integrated delivery systems (Care Coordination Entities, Accountable Care Entities) CountyCare, an integrated delivery system for individuals newly eligible under Medicaid | <p>Medicaid enrollees (FFS and managed care), some with special needs (e.g., frail elderly, seriously mentally ill, justice-involved, homeless, HIV-impacted, developmentally disabled)</p> <p>Commercial payer covered lives, if payers choose to participate</p> | <ul style="list-style-type: none"> Expands on existing definitions in Medicaid, called Care Coordination Entities and Accountable Care Entities Responsible for providing or arranging services in primary, specialty, behavioral health, inpatient, and long-term care Governance structure to distribute performance-based payments Use of common care plan Additional types of social service providers involved for special populations |
| Iowa | <ul style="list-style-type: none"> Commercial payer ACO contracts Medicare ACOs Medicaid FFS contracts with regional ACOs (launched on Jan 1, 2014 through the Health & Wellness Plan) | <p>Individuals not eligible for Medicaid whose income is under 100% FPL</p> <p>Medicaid enrollees</p> <p>Commercial payer covered lives, if payers choose to participate</p> | <ul style="list-style-type: none"> Builds on existing definitions Regionally based entities Builds on performance measurement methodology used by the commercial payer Wellmark with its ACOs Eventually integrate long-term care services and supports and behavioral health services |

(continued)

Table 3-8. Comparison of accountable care models across Model Design and Pre-Test states (continued)

| State | Existing Initiatives | Proposed Populations Served | Key Features of Proposed Accountable Care Model |
|--------------|---|---|--|
| Michigan | <ul style="list-style-type: none"> Commercial payer ACO contracts Medicare ACOs | <p>Medicaid enrollees in three pilot regions who are not already participating in other demonstrations or other special programs</p> <p>Commercial payer covered lives, if payers choose to participate</p> | <ul style="list-style-type: none"> Defined as new entity called Accountable Systems of Care, or ASCs Requirements for ASCs to be defined through state regulations or through future Medicaid managed care contracts Responsible for integrating clinical care across settings Primary care practices are PCMHs May be managed care organizations |
| Pennsylvania | <ul style="list-style-type: none"> Medicare ACOs | <p>Medicaid, CHIP, dually eligible</p> <p>State government employees</p> <p>Commercial payer covered lives, if payers choose to participate</p> | <ul style="list-style-type: none"> Defined as new entity Accountable Provider Organizations, or APOs Integrates Care Management teams for complex, high-cost Medicaid patients Uses Episode of Care payments (if payers and providers choose to; Medicaid will) for selected conditions or services (to be determined) |
| Utah | <ul style="list-style-type: none"> One Medicare ACO Medicaid contracts with ACOs to cover 70% of Medicaid enrollees | <p>Medicaid enrollees currently in ACOs</p> <p>Commercial payer covered lives, if payers choose to participate</p> | <ul style="list-style-type: none"> Can be Medicare ACO definition, Medicaid ACOs (partially value-based), or multiple models to be defined by voluntarily participating payers |
| Washington* | <ul style="list-style-type: none"> Medicare ACOs | <p>Medicaid enrollees</p> <p>Commercial payer covered lives, if payers choose to participate</p> | <ul style="list-style-type: none"> Defined as new entity called Accountable Risk-Bearing Entities, or ARBEs Regionally based entities May be managed care organizations, county government, or community-based organization Capacity to assume full financial risk for physical or behavioral health services of a defined population |

* Indicates Pre-Test state.

Abbreviations: ACO = accountable care organization, CHIP = Children’s Health Insurance Program, FFS = fee for service, FPL = federal poverty level, HIV = human immunodeficiency virus, PCMH = patient-centered medical home.

3.4.1 Variations in Proposed Accountable Care Models

States’ proposals to change the organization of health care delivery toward greater integration across health care settings and provider types, through implementation of an accountable care model, vary with regard to the specificity with which these models are defined in the Plans. States that are extending existing models already operating within their borders offered more details, while states that generated these ideas during the Model Design process left the door open to further definition during a later implementation phase.

The accountable care models proposed in each state differ on the following dimensions: (1) type of entity that bears financial risk for the care provided, (2) model for sharing risk between payer and the risk-bearing entity, (3) scope of payer involvement and population served, and (4) scope of services included under the risk arrangement. The different payment contracts that currently exist between commercial health plans and provider organizations, which states do not want to disrupt, are one reason for variation along these dimensions. In addition, in some states the Medicaid program influenced the definition of accountable care, either to align with existing Medicaid accountable care initiatives or to tailor the accountable care models to meet the needs of selected subpopulations insured by Medicaid. These comparisons are explained in more detail below.

Risk-bearing entity. States that described an accountable care model in their Plans proposed that one of three entities would assume financial risk for the health care of a population: (1) a provider-driven entity; (2) an MCO; or (3) a coalition led by a provider, MCO, or other organization that operates at a regional level.

Delaware, Illinois, Michigan, and Pennsylvania envisioned a system in which provider-driven entities would assume risk for a defined patient population. Delaware proposed giving providers and payers the option of aligning with the Medicare ACO definition, or of defining new delivery systems, to move toward value-based purchasing. The Illinois Plan built on the accountable care program already launched under Medicaid, in which provider organizations that are forming to accept risk could next contract with commercial payers. In Michigan and Pennsylvania, the states' Plans seemed to be inviting provider organizations to self-identify as potential new entities that would accept some degree of risk (shared savings, prospective capitation, or full financial risk) for the population attributed to them by participating payers.

Under the Michigan Plan, MCOs could also become Accountable Systems of Care. The Utah Plan emphasized a transition to what it called "full" value-based purchasing by all payers. Medicare ACOs were seen as fully value-based, in that they include appropriate quality metrics along with capitation, but the state's existing Medicaid contracts with its ACOs are only partially value-based. Other approaches were expected to evolve.

Colorado, Iowa, Michigan, and Washington proposed accountable care arrangements that would cover specific regions. In Colorado, the foundation for this model of care are seven regionally based organizations, one of which already has a global payment contract with Medicaid (set to begin in July 2014) to cover physical, behavioral, and substance abuse services for the Medicaid population with family incomes below 250 percent of the federal poverty level. Iowa planned to identify six regional ACOs to serve segments of its low-income or Medicaid population; the regions were defined to reflect existing Medicaid practice and referral patterns. Michigan proposed initially piloting its ASCs in three regions. Finally, Washington planned to have its Medicaid program and state employees' health plans contract with Accountable Risk-

Bearing Entities (ARBEs), which the state defined as either “managed care plans, risk-bearing public-private entities, county governmental organizations, or other community organizations” that would have the capacity to assume full financial risk for physical or behavioral health care for regionally defined populations. Regionally based Accountable Communities of Health (later named Accountable Collaboratives for Health, ACHs) would select the ARBEs under a procurement process. ARBEs would incorporate services the ACH has identified, meet the regional population’s needs, and be aligned with service areas of other state programs run by the Department of Social and Health Services, the Department of Labor, and the Department of Early Learning.

Model for sharing risk. Under the accountable care model, all states proposed to share risk for the cost of the attributed populations using either a shared savings/risk model or a fully capitated payment method. However, most states proposed moving accountable entities toward this payment model in phases, or would offer options in the extent to which providers are at risk for cost. Colorado and Illinois would allow payers and new accountable delivery systems to begin with an enhanced fee- or pay-for-performance type of arrangement. Delaware and Michigan would give providers and payers options as to whether the provider has upside risk (“bonuses” if quality and cost expectations are met) or both upside and downside risk (provider must pay if costs exceed expectations). Pennsylvania would expect providers to accept both upside and downside risk. Five states (Illinois, Iowa, Michigan, Utah, and Washington) would give providers or other risk-bearing entities the option to start with or to move toward full capitation or global payments.

Scope of payer involvement and populations served. Most states with an accountable care component in their Plans intended to move all or part of their Medicaid-covered populations toward receiving care from an integrated delivery system, either based on the region where they live (Colorado, Iowa, and Washington; this is already the policy in Utah) or their usual providers *if* those providers form accountable entities that contract with Medicaid. In some cases, Medicaid would direct its contracted MCOs to adopt contracts with providers that form risk-bearing entities. Pennsylvania and Washington would also commit to using their public employees’ health plan to support the delivery of care through these new entities (accountable provider organizations [APOs] or ARBEs, respectively). Delaware and Iowa explicitly proposed to invite Medicare to align current ACO payment and measurement policies with the proposed state accountable care model. All states would rely on voluntary participation of commercial payers to adopt an approach to contracting with these ACOs or accountable entities, but acknowledged that some portion of their commercially or privately insured population may already be receiving care from providers in ACO or other value-based purchasing arrangements.

Scope of services included under risk arrangement. Three states not building on an existing accountable care model (Delaware, Michigan, Pennsylvania) would largely focus on the

integration of physical health care services. Three other states (Colorado, Illinois, Iowa) would build on an existing accountable care model. The proposed scope of services included under the risk arrangement in these three states varies, but in general includes a broad range of physical and behavioral services and LTSS, for which entities would be accountable. For example, the Colorado Plan focused on existing Regional Care Collaborative Organizations that support networks of primary care providers via care management, coordination, and administrative services. Although current efforts would focus on integrating behavioral health care with primary care in a value-based payment model, eventually the Plan envisioned that provider networks would also use a global payment covering public health, oral health, long-term care, and social and community support services. Similarly, the proposed model in Illinois defines the integrated delivery systems that would be accountable for cost and quality to include a network of long-term care and behavioral health providers, in addition to physical health care providers and service providers for special populations (e.g., patients living with HIV/AIDS). Iowa would begin with physical health care providers and eventually incorporate accountability for behavioral health and LTSS.

3.4.2 Policy Levers

Most of the states' Plans would rely on changes to Medicaid payment and contracting policies to foster transformation to accountable care models, although the strength of that lever and other policy levers to spread this model to commercial payers varies. In addition, states began the SIM Model Design process from different state policy contexts, so variation in the policy levers that states would use is expected. For example, Iowa, Illinois, and Utah already had state legislation that enabled or required their Medicaid program to enter into payment agreements with providers that incorporated some risk-sharing element or explicitly allowed payments to accountable entities. In Delaware, where most Medicaid-covered lives are enrolled in managed care, contracting with the Medicaid MCOs is a sufficient policy lever to encourage Medicaid payments to ACOs within these MCOs; Michigan also proposed using this lever.

All states identified regulations and policies that would be barriers to allowing state Medicaid programs to pay accountable provider networks and that would need to change. Colorado proposed to revise a regulation that prohibited the same provider from billing for physical and mental health care services provided to the same patient in the same day. Illinois would change a rule that prohibits Medicaid from contracting with groups of providers, and another rule that restricts payment for mental health services to only certain providers.

Beyond revisions to Medicaid policy, states had relatively weak policy levers to use to align other payers in support of the accountable care model. All states implied that voluntary cooperation of payers would yield multi-payer support of ACOs or other accountable entities. Only Illinois, Pennsylvania, and Washington explicitly proposed using their state employee health plan benefit program as a lever with commercial payers.

Some states explicitly avoided issues that require legislation, because of a political climate favoring voluntary rather than government action (Iowa, Michigan, Pennsylvania, Utah) or because stakeholders had the sense that passing legislation would be difficult. Stakeholders in Utah, for example, repeatedly referred to their intention to “accelerate” and assess developments, rather than impose selected forms of accountable care. In one case—Washington—stakeholders noted that legislation would be possible; in most other states, however, this would be achieved through voluntary alignment of payers, despite opinions from most stakeholders that voluntary action would be insufficient.

Other common policy issues include removing restrictions against sharing health information across health care providers, including proposing changes to state law (Illinois), state regulation (Pennsylvania), and advocating for changes to federal law—for example, the law that constrains disclosure of substance abuse treatment information without prior patient consent (Colorado, Illinois). Michigan and Pennsylvania also identified antitrust law as a potential issue to overcome in allowing providers to create accountable networks and payers to implement similar payment reform, although their Plans did not propose specific policy changes.

3.4.3 Implementation

In most of the states discussed in this section, implementation of the accountable care model in the short term seemed likely for their Medicaid programs. In fact, most states proposed changes to Medicaid policy as the foundation supporting accountable care model implementation. However, in four of the eight states (Colorado, Illinois, Michigan, and Washington), some stakeholders were concerned that commercial payers may not align with the same accountable care model that Medicaid would adopt, although this alignment generally was expected to occur eventually.

In some states, stakeholders were positive about the feasibility of implementing this model because of a similar existing program under Medicaid (Illinois, Iowa), or other infrastructure that would ease providers’ transition to an ACO (e.g., the Medicare Multi-Payer Advanced Primary Care Demonstration in Michigan and Pennsylvania). In addition, stakeholders in Iowa were optimistic about implementation because: (1) the state adopted the dominant payer’s quality measures for use in the state-contracted ACOs, and (2) 70 percent of the state’s population receives health care benefits paid by the state and the dominant insurer.

Stakeholders identified potential threats to implementing the proposed accountable care model related to either characteristics of the Medicaid market, commercial market, or provider community; or the readiness of the infrastructure intended to support the accountable care model. For example, even where Medicaid would be implementing this model, stakeholders expressed concern about the implications for health plans and providers. In Colorado, stakeholders were uncertain as to how the existing Medicaid behavioral health carve-out plan, which makes

capitated payments through five regional behavioral health organizations, would integrate with a new delivery system model. Similarly, in Michigan, some stakeholders thought requiring MCOs to contract with or become ACOs might introduce a redundant layer of bureaucracy, since Medicaid MCOs already engage in many ACO-like activities and are already paid on a capitation basis (as Michigan's ASCs could choose to be paid). The Iowa Plan stated that behavioral health care would be incorporated into the ACO delivery system model at a later stage, but doing so would undermine efforts to redesign the Medicaid behavioral health care system already set to go into effect.

Commercial payers' adoption of the accountable care model also influences the potential for implementation in states. In Colorado and Illinois, stakeholders implied that the proportion of health care payments controlled by the state (i.e., Medicaid and potentially the state employee benefit plan) would not be sufficient to drive change in the health care system. In Illinois, where all but one commercial payer had business in other states, stakeholders expressed particular doubt that the payers would adopt a common set of quality metrics or could negotiate individual provider contracts easily.

Another overarching concern was whether providers would be willing or able to participate in an accountable care model. Stakeholders in Colorado questioned whether providers had the ability to take on this level of accountability; in Iowa, providers were not sure if they would qualify to participate in the proposed ACO model. In Illinois, stakeholders expressed doubt that providers would adopt a common health IT platform to share health information and calculate quality metrics. In Washington, stakeholders indicated that local health departments may not have been deeply engaged early in the planning process, but they would be necessary to support regionally based service procurement through the ACHs; some stakeholders were pessimistic about local health departments' support for implementation of the ACHs.

Yet another factor that could affect implementation of an ACO-like model is the degree to which the infrastructure is ready to support it. For example, stakeholders in Michigan were skeptical that planned database enhancements to support ACOs and other Plan components would be ready in time. Stakeholders in Illinois noted that few available state agency staff had the institutional knowledge of Medicaid to support a major new initiative like this, particularly at the same time that other significant health care policy changes were taking effect.

One common concern across these states was that stakeholders did not know enough about the details of how the Plans would be implemented to determine whether it would be feasible (Delaware, Illinois, Michigan, Washington). In another state (Iowa), stakeholders expressed concerns about the ACO model itself and whether it would meet the needs of populations (such as pediatric populations and rural populations) and be sustainable (if already-efficient providers could not produce anticipated savings). In Washington, multiple stakeholders

raised concerns with the feasibility of implementing ACHs that are effective in responding to community needs. Further, stakeholders in several states questioned the adequacy of the evidence base for adopting an accountable care model to improve patient and financial outcomes.

Finally, stakeholders in three states preparing for a fall 2014 gubernatorial race (Illinois, Iowa, Pennsylvania) commented that a change in Governor in their state could derail the overall direction of the delivery and payment system changes proposed in their Plans.

3.5 Episodes of Care Payment Models

Only three Model Design states—Ohio, Pennsylvania, and Tennessee—proposed episodes of care (EOC) payment models in their respective Plans. Further, this model was not the only delivery or payment model innovation proposed in these state’s Plans. Ohio and Tennessee’s EOC models were similar, with both proposing to use similar policy levers. Pennsylvania proposed EOC use as an optional strategy, with details regarding implementation not yet defined.

All three states proposing EOC models have experience with the Innovation Center’s Bundled Payments for Care Improvement (BPCI) Initiative. Under this model, either a single prospective lump sum payment is made to a single provider for an illness or course of treatment or total expenditures are retrospectively reconciled against a target price. By aligning incentives among providers, this model has been shown to increase coordination across providers. The extent to which the BPCI experience of organizations within Ohio, Pennsylvania, or Tennessee substantively informed the state’s proposed approach is not clear. The Ohio Plan cited the state’s experience with BPCI as part of the rationale for selecting an EOC approach, but stakeholders reported that the state intends to take a new approach toward EOC rather than to expand on previous initiatives. The Tennessee and Ohio Plans explicitly described their respective EOC strategies as adaptations from the Arkansas EOC payment model.

3.5.1 Variations in Proposed Episode of Care Models

In Tennessee, the EOC model is one of three delivery and payment innovations proposed in the Plan but, based on stakeholder reactions, seemed to receive the most attention and development during the planning process. Ohio proposed its EOC model as part of a complementary strategy to PCMH for shifting toward total cost of care accountability. Pennsylvania proposed EOC as an optional strategy for private payers and providers to use in conjunction with PCMH and ACO models, to align payer and provider incentives for coordinated care around explicit conditions and clinical care pathways.

All three state Plans proposed EOC related to pregnancy services and acute asthma exacerbations; additional episodes of care included in each state’s Plan are described in [Table 3-9](#). Ohio and Tennessee shared a similar strategy for selecting episodes, preferring episodes that:

(1) represent a substantial proportion of expenditures, (2) exhibit a wide variation in costs, (3) are already in use or perceived as feasible to implement, and (4) cover a diverse set of providers and patients. Pennsylvania did not provide details regarding episode selection for its Plan.

Table 3-9. Initial episodes of care proposed by Ohio, Pennsylvania, and Tennessee

| Initial Episodes of Care Proposed | Ohio | Pennsylvania | Tennessee |
|--|------|--------------|-----------|
| Chronic obstructive pulmonary disease exacerbation | – | X | – |
| Congestive heart failure | – | X | – |
| Joint replacement | X | – | X |
| Percutaneous coronary intervention for coronary artery disease | X | – | – |
| Pregnancy-related services | X | X | X |
| Severe asthma exacerbation | X | X | X |

X Indicates is present in the state’s Plan.

The Ohio and Tennessee EOC models are similar; both would use FFS payments with additional payments made based on a retrospective assessment of quality measures and average episode costs, and including upside and downside risk. Each payer would determine its own gain-sharing thresholds and limits, stop-loss limits, and risk adjustment methodologies. Pennsylvania’s approach was less defined, with options for either FFS with retrospective payments or prospective bundled payments. In addition, Pennsylvania’s Plan would include models with upside risk only as well as models with both upside and downside risk. Tennessee and Ohio had similar rationales for selection of a retrospective model. Both states thought this model would take a shorter amount of time to implement and would build on the existing FFS model, avoiding the need for extensive provider negotiations and new business relationships required to divide a prospective global payment.

3.5.2 Policy Levers

Tennessee and Ohio would include use of EOC models in their Medicaid MCO contracts and possibly in contracts for their state employee health plans. Both states proposed using Medicaid section 1115 waivers, SPAs, or both to implement. In contrast, Pennsylvania would provide data showing cost variation to encourage voluntary adoption by its Medicaid MCOs. All three states would rely on voluntary adoption of EOC payments among commercial insurers and self-insured employers. However, Ohio’s Plan proposed an assertive role for the state with respect to driving voluntary adoption of the model in the broader health care market, and commercial payers in Ohio have demonstrated enthusiasm for this model. As part of the planning process in Ohio, a multi-payer coalition developed an EOC charter, and this would form the foundation of further efforts to develop and coordinate the model with payers and

providers throughout the state. Further, the Plan stated that private payers are committed to launching some of the episodes at the same time they are implemented in Medicaid.

3.5.3 Implementation

Ohio's long-term goal was for 50 to 60 percent of health care spending in the state to use an EOC model, while Tennessee's goal was for EOC to cover between 25 and 30 percent of Medicaid spending by 2016. Pennsylvania's Plan did not articulate any long-term goals for the EOC model.

Tennessee has moved forward with implementation of the EOC model within its Medicaid program, with a 6-month test period for the three initial episodes of care beginning on January 1, 2014, and proposed to transition to the payment model beginning in July 2014—with projected implementation of up to 75 episodes over 5 years. Ohio would implement the five episodes it would define within the first year of Plan implementation with up to 20 additional episodes implemented over 3 years. Pennsylvania proposed to refine the EOC methodology beginning in the first year, but a specific timeline for actual implementation was not specified.

Despite enthusiasm for inclusion of EOC in Ohio's Plan, the feasibility of implementing EOC in Ohio was less certain in the absence of a Round 2 Model Test award because, relative to the PCMH component, stakeholders considered the work involved in implementing EOC to be new and technically complicated. However, with adequate funding implementation was thought to be technically and politically feasible. Although Tennessee has already moved forward with EOC implementation in Medicaid, stakeholders were not in agreement as to whether it could be implemented in the state employee health plan or commercial payers by summer 2014, and saw resistance from hospitals and other providers as the biggest threat to overall implementation. Stakeholders were also skeptical about whether Tennessee could develop up to 75 episodes as planned, given the intense effort and process required for the first three episodes. Because EOC was a rather minor component to Pennsylvania's plan and portrayed as an optional strategy, the feasibility of implementation was not mentioned by stakeholders.

3.6 Other Delivery System Enhancements

Many states' Plans included enhancements to the health care delivery and payment system for a particular sector, such as behavioral health and LTSS, or a special population group, such as pregnant women, individuals at the end of life, and medically or socially complex patients.

3.6.1 Behavioral Health Care

All states' Plans encouraged greater integration of physical and behavioral health care, generally through changes in payment models or encouragement of co-location of providers. Several states proposed additional ways to enhance behavioral health care in their states. The

Hawaii and Utah Plans included specific emphasis on enhancing telehealth and additional training opportunities for primary care providers to facilitate access to behavioral health care. For example, Hawaii proposed to implement learning collaboratives for primary care providers, to increase their knowledge and training in addressing behavioral health issues within the primary care setting. The Hawaii Plan also proposed to renew its Medicaid section 1115 waiver to create infrastructure at the state level (funding a behavioral health coordinator and three policy analysts) to address statewide behavioral health policy issues. Utah proposed to leverage its Area Health Education Centers infrastructure to provide training in rural hospitals on implementing peer support programs and telehealth, and addressing behavioral health issues.

Maryland and Michigan proposed using outside organizations (described below as enabling strategies) to offer resources that would help integrate physical and behavioral health care. These organizations are Community Health Hubs in Maryland and Community Health Innovation Regions in Michigan. Finally, the Ohio and Texas Plans included a health IT strategy to expand behavioral health care providers' access to EHRs and HIE.

3.6.2 Long-Term Services and Supports

Plans from Colorado, Idaho, Illinois, Iowa, Michigan, and Rhode Island indicated that LTSS would be included in the global payments to principal accountable providers or other risk-bearing entities under the new value-based purchasing models, usually in a later phase of model implementation. New Hampshire, Tennessee, and Hawaii proposed delivery system enhancements that apply specifically to LTSS.

The New Hampshire Plan included delivery system changes designed to increase access to home and community based services (HCBS) within its Medicaid program using three primary mechanisms: (1) expanding its consumer-directed care program that allows individuals to control their own LTSS budgets; (2) establishing a “team coordinator” role—someone who would be trained and certified to help qualified Medicaid consumers coordinate with providers and manage budget; and (3) integrating LTSS into the health home. The New Hampshire Plan offered additional supporting strategies, such as incorporating incentives to participate in public health programs into the design of person-directed LTSS budgets and integrating substance abuse treatment into LTSS. Additionally, the Plan proposed modifications to existing legislation that would include LTSS providers as participants in the HIE. However, stakeholders expressed concern over whether the New Hampshire Plan had sufficient buy-in from commercial insurers, Medicaid MCOs, and providers.

The LTSS component of Tennessee's Plan proposed to restructure payments to nursing facilities, then payments to HCBS providers, so that payments would include some aspect of prospective payment with an adjustment based on measures of quality. In addition, Tennessee Medicaid would align Medicare and Medicaid benefits for dually eligible beneficiaries by

promoting voluntary enrollment in the same MCO. This activity would be informed by an effort funded by the Robert Wood Johnson Foundation, Quality Improvement in Long-Term Services and Supports, which conducted its own process to garner consumer and provider feedback in parallel with the SIM-funded process. Tennessee proposed to use a Medicaid section 1115 waiver to enable these changes in payment and managed care contracting for LTSS.

Three other states proposed LTSS-related activities to supplement the delivery system and payment models envisioned in their Plans. Hawaii proposed to initiate or enhance activities to increase coordination of services for aged and disabled persons, and Texas and Utah both proposed expanding health IT access to LTSS providers.

3.6.3 Maternity Care

California, Texas, and Washington proposed activities to improve maternity care quality and lower costs in their states. The California Plan would build on existing models within the state and leverage the state's purchasing power to change hospital performance in maternity care and encourage other large employers and health plans to adopt the models. In particular, the California Public Employees' Retirement System, which manages health benefits for state employees, would pay hospitals a blended rate for deliveries in 2015 to eliminate the higher reimbursements and thereby reduce incentives for elective C-sections.

The Texas Plan included "maternity homes" that it would promote through learning collaboratives across the state. In Washington, maternity care was the focus of a set of shared decision-making tools that the state's Plan proposed to develop and certify. Washington would coordinate with state-financed contractors to implement various tools available through local and national organizations, including the Informed Medical Decisions Foundation Maternity Care Shared Decision Making Initiative.

3.6.4 End-of-Life Care

Plans in California, Utah, and Washington outline a set of activities that would change provider and patient behavior during end-of-life care. The California Plan proposed integration of palliative care services in its health home model, and in parallel, would expand programs in place at hospitals related to educating patients and providers and reducing structural barriers to palliative care delivery. California also proposed to pursue a Medicare hospice waiver to allow enrollees to obtain palliative and curative care concurrently.

The Utah Plan proposed to enable better end-of-life decision making across the state. Building on work conducted by the Salt Lake City Beacon Community, a grant program funded through the Office of the National Coordinator (ONC), the Plan proposed to automate decision-making tools and transfer information like the electronic Physician Order of Life Sustaining Treatment (ePOLST). Utah would rely on state investment in resources to conduct an

educational campaign to consumers, increase use of a standard form for advanced directives, and implement ePOLST.

Similar to its approach to improving maternity care, Washington proposed to advance the use of shared decision making tools regarding end-of-life care. These tools would be disseminated through the existing Dr. Robert Bree Collaborative.

3.6.5 Care for Medically or Socially Complex Patients

The delivery system and payment models most states proposed in their Plans are intended to improve care coordination and services for medically and socially complex patients. The Plans from Hawaii, Pennsylvania, and Rhode Island described development of supplemental services to address the highest need patients served by the health care system. The Hawaii Plan proposed three programs to provide direct care, coordination, and social assistance to patients with frequent health care system encounters. These programs would focus on three high-risk populations: high users with risk factors such as homelessness, mental illness, and substance abuse; high users of emergency rooms in rural areas; and individuals with frequent interaction with the justice system. These programs are also expected to reduce racial/ethnic disparities within these populations. Hawaii proposed renewal of its Medicaid section 1115 waiver and a Health Home SPA as policy levers for this aspect of its Plan.

Under the Pennsylvania Plan, the Pennsylvania Medicaid program would fund 50 teams to support PCMH practices, APOs, and large primary care practices (i.e., FQHCs) to address the needs of Medicaid patients who exceed support capacity available through the practice.

The Rhode Island Plan proposed to address the needs of high users of emergency departments by offering alternative access points to care—such as home-based primary care, ambulatory intensive care units, and sobering services. In addition, Rhode Island would consider use of community health teams comprising nurses, social workers, dietitians, pharmacists, and other professionals—outside and within primary care practices—to serve persons with behavioral/substance abuse problems and other chronic conditions.

3.7 Enabling Strategies Overview

All states proposed strategies to enable the development or spread of delivery and payment system reforms and increase their effectiveness. The set of proposed strategies varied considerably across the states, but generally included activities in one or more of the following categories: workforce development, health IT infrastructure, data aggregation and analytics, public health approaches, infrastructure to support delivery system transformation, and consumer engagement. Some states proposed one or more of these strategies as a main component of their Plan, whereas others considered them as supporting activities.

3.7.1 Workforce Development

The Plans from all 19 states included one or more strategies for developing the health care workforce. One of the most common strategies, proposed by 14 states, is to invest in training that would be offered to different providers to support their involvement in new models of care—such as team-based care or integration of primary and behavioral health care. Sources of funding for this training varied, but included Medicaid section 1115 waiver (Illinois), Round 2 Model Test award and the Balancing Incentive Program funds (New Hampshire); or in-kind support through changes in health education curricula (New York, Pennsylvania), other private-sector programs (Rhode Island, Washington), ACO-provided training (Iowa), or a mix of public and private training efforts (Utah).

Nine states proposed integrating CHWs into the health care workforce. Depending on the state, this would require a new law (Illinois), new regulations for CHW training and certification (Maryland, Michigan), new actions in the state executive agencies to offer credentialing (Colorado, Rhode Island) or education (Hawaii, Washington), new funding from a Round 2 Model Test award (Maryland), or voluntary payer actions (Maryland).

Another nine states proposed enhancing their tracking of the health care workforce census. Several states already had existing authority (Colorado, Iowa, Rhode Island) or federal funding (Hawaii) to do so. The other states suggested enhancing data collection systems and surveillance to monitor workforce supply (Connecticut, Delaware, Michigan, New York, Ohio, Tennessee, Utah).

At least seven states included the strategy of health care workers practicing “at the top of their license/education/training” (Connecticut, Delaware, Illinois, New York, Tennessee, Texas, Washington). With the exception of Delaware, which proposed creating new guidelines for scope of practice, and Illinois, which proposed new regulation, other states identified this as a goal without citing an explicit mechanism they would use to make it happen. Four states identified the related goal of deploying existing untapped resources within the health care workforce to support new models of care (Idaho, Illinois, New York, Washington). For example, Illinois proposed to credit military training toward education requirements of Illinois-approved licensed practical nurse programs. Idaho proposed to use emergency medical services personnel to extend the PCMH.

States also identified strategies to improve recruitment and retention of health care providers to underserved areas, some with more specificity than others. For example, Idaho proposed to increase funding for medical education scholarships tied to minimum in-state practice requirements, and increase the number of medical education slots at schools with training in rural health care. Five states proposed changes to graduate medical education (GME) programs, such as changing the curricula; but only one state (Illinois) proposed to fund a GME

pilot program as part of a new proposed Medicaid section 1115 waiver. Five states proposed new loan repayment programs to align with workforce priorities, and five states proposed to develop residency programs to help retain critical members of the health care workforce.

Finally, a few states proposed to increase the behavioral health care workforce, by changing payment policies (Colorado and Illinois), and by increasing telehealth opportunities and funding more counselors and therapists, peer support training and certification, and expanded behavioral health training, mostly in rural areas (Utah). Additionally, several states proposed to integrate lay health workers (other than CHWs) into the health care workforce (community paramedics—Hawaii, Illinois; patient navigators—Colorado, Rhode Island; care coordinators—Delaware; peer support counselors—Utah); and to develop the cultural competency of the health care workforce (Connecticut, Hawaii, Washington). The policy levers for these strategies are largely to be determined.

3.7.2 Health IT

Enabling health IT strategies have been well under way in most states as a result of the federal Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009; and many state-led programs and initiatives either predate HITECH or were developed soon after to leverage HITECH investments. Plans and stakeholders most commonly mentioned ONC State HIE and Regional Extension Center Cooperative Agreements, ONC HIT Trailblazer Initiatives, and ONC HIE Challenge Grant Programs. In addition, several states (California, Colorado, Hawaii, Ohio, Michigan, New York, Pennsylvania, Rhode Island, Utah, and Washington) had prior ONC Beacon Community awards to advance the use of health IT. As a result, all states had some mix of a preexisting state health IT strategic plan, state health IT initiatives, or various regional health IT projects at the start of the planning process. The degree to which health IT initiatives were already in place did not seem to influence the delivery system and payment models that states included in their Plans; rather, states' Plans identified a vision for how future health care delivery would be supported by future health IT and the Plans included strategies for the achieving the future health IT needs.

Although most states discussed the enabling health IT strategies required for Plan implementation, few provided details or a timeline for implementation. Further, it was difficult to discern from either the Plans or talking with stakeholders in the state what health IT strategies were attributable to the SIM planning process and what may have already been in progress. Stakeholders identified funding as a significant barrier to implementation of enabling health IT strategies; hardware and infrastructure costs are the major expense, although states would also require funding for incentives and robust technical assistance. Many states proposed a Round 2 Model Test award in addition to leveraging existing federal health IT cooperative agreements as the source of funding for needed health IT investments. Further, lack of widespread broadband in rural areas was identified as a barrier in some states; further investments in the general IT

infrastructure would need to occur before further investments in health IT can be made in those areas.

Enabling health IT strategies proposed by state Plans can be categorized as: (1) promoting further EHR adoption and HIE connection by practices, (2) further development of statewide HIE capacity and functionality, (3) telehealth development, and (4) consumer engagement through technology. In many states, the proposed health IT strategies are not new, but were adapted from existing state health IT initiatives, strategic plans, or taskforces. These proposed strategies are briefly described below.

Electronic Health Records adoption. Because the ability to electronically share individual clinical information among multiple providers is the cornerstone of coordinated care envisioned under most new models of health care delivery and value-based payment, EHR adoption is a fundamental component of almost all state Plans. As of October 2013, Model Design and Pre-Test states varied with respect to the percentage of professionals (physicians, nurses, and physician assistants) and hospitals within the state receiving payments under the Medicare or Medicaid EHR Incentive Programs (see [Table 3-10](#)). As compared to professionals, hospitals in all states are much further along with EHR adoption. Among the 19 state awardees, Delaware, Illinois, Iowa, Ohio, and Washington have the highest professional and hospital participation; Connecticut, Idaho, Texas, and Utah have the lowest participation of both professionals and hospitals.

Whereas many states proposed to focus on increasing EHR adoption, some would focus more on adoption of basic EHR functionality by those practices not currently using EHRs, and others would focus on helping practices with EHRs adopt more advanced EHR features aligned with proposed value-based payment methods. For example, New York would promote adoption of EHRs linked to both the state's HIE (described in more detail below) and the regional entities that would support integrated and coordinated care through PCMHs. Common strategies proposed by states to increase EHR adoption include technical assistance and toolkits for the selection and implementation of robust EHR systems that would meet requirements for interoperability and meaningful use, promotion of practice participation in existing federal and state EHR incentive programs, and creation of new or promotion of existing state incentive programs to promote EHR adoption. A number of states proposed to intensify efforts to encourage EHR adoption by small and rural practices, which make up the majority of practices that have yet to adopt EHRs. In addition, some states would target other types of providers for EHR adoption, including behavioral health providers, long-term care providers, rehabilitation providers, and CHWs. For example, Iowa proposed to support the implementation of hosted "EHR-light" portals for community providers who are unlikely to implement robust EHR systems.

Table 3-10. Share of professionals (physician, nurse practitioner, physician assistant) and nonfederal acute care hospitals in the state paid under Medicare or Medicaid EHR incentive programs as of October 2013 (HealthIT.gov, 2013)

| | Professionals | | Hospitals | |
|-----------------|---------------|-----------------------|-----------|-----------------------|
| | Percent | Quintile ^a | Percent | Quintile ^a |
| National | 36 | n/a | 77 | n/a |
| California | 47 | Second highest | 89 | Middle |
| Colorado* | 44 | Middle | 84 | Second lowest |
| Connecticut | 39 | Second lowest | 84 | Second lowest |
| Delaware | 57 | Highest | 100 | Highest |
| Hawaii | 37 | Second lowest | 65 | Lowest |
| Idaho | 36 | Second lowest | 67 | Lowest |
| Illinois | 50 | Second highest | 91 | Second highest |
| Iowa | 62 | Highest | 94 | Highest |
| Maryland | 33 | Lowest | 93 | Highest |
| Michigan | 43 | Middle | 82 | Second lowest |
| New Hampshire | 53 | Highest | 81 | Second lowest |
| New York* | 35 | Lowest | 87 | Middle |
| Ohio | 52 | Highest | 91 | Second highest |
| Pennsylvania | 46 | Highest | 90 | Middle |
| Rhode Island | 33 | Lowest | 91 | Second highest |
| Tennessee | 43 | Middle | 89 | Middle |
| Texas | 40 | Second lowest | 84 | Second lowest |
| Utah | 37 | Second lowest | 47 | Lowest |
| Washington* | 55 | Highest | 98 | Highest |

^aQuintile based on distribution of all 50 states, not just SIM Model Design or Pre-Test states.

* Indicates Pre-Test state.

Health information exchange. In addition to EHR adoption, an existing health IT infrastructure must be in place to facilitate the exchange of information among providers. Most states have launched state-designated HIEs in addition to regional HIEs that may have already existed prior to the state-designated HIE entity. As of Second Quarter 2013, only California, New Hampshire, and Tennessee do not have broadly available HIE capabilities. In contrast, Colorado, Delaware, Maryland, New York, Rhode Island, and Utah have broadly available directed and query-based exchange capabilities—the latter representing a higher level of integration and functionality.

Despite broad availability of HIE capabilities, most states acknowledged that the promise of more coordinated care cannot be realized unless providers (i.e., practices, pharmacies, labs, hospitals) choose to connect their information systems to an HIE. With the exception of Iowa, all have rates of community pharmacy participation in electronic prescribing exceeding 90 percent. **Table 3-11** shows the percentage of hospitals able to share laboratory results electronically with providers outside their system, which is an important functionality for HIE and a critical component of the care coordination required for transformation to value-based delivery and payment models. Although some variability exists, all but two of the states are in the top three quintiles of states ranked according to the percentage of hospitals sending laboratory results to outside providers—suggesting an increased readiness among these states for reforms dependent on HIE. Although much progress has been made, widespread *bidirectional* exchange among private practices, hospitals, and other entities still lags in most communities.

Table 3-11. Hospitals sharing lab results electronically with providers outside their systems as of 2012 (HealthIT.gov, 2013)

| | Percent | Quintile ^a |
|-----------------|---------|-----------------------|
| National | 36 | N/A |
| California | 53 | Middle |
| Colorado* | 71 | Highest |
| Connecticut | 75 | Highest |
| Delaware | 100 | Highest |
| Hawaii | 52 | Middle |
| Idaho | 59 | Second highest |
| Illinois | 58 | Middle |
| Iowa | 35 | Lowest |
| Maryland | 70 | Second highest |
| Michigan | 69 | Second highest |
| New Hampshire | 73 | Highest |
| New York* | 72 | Highest |
| Ohio | 72 | Highest |
| Pennsylvania | 57 | Middle |
| Rhode Island | 85 | Highest |
| Tennessee | 69 | Second highest |
| Texas | 44 | Second lowest |
| Utah | 62 | Second highest |
| Washington* | 75 | Highest |

Source: Office of the National Coordinator for Health IT, U.S. Department of Health and Human Services <http://dashboard.healthit.gov/HITAdoption/?view=2>.

^aQuintile based on distribution of all 50 states, not just SIM Model Design or Pre-Test states.

* Indicates Pre-Test state.

Many Plans proposed strategies that encourage provider connection to one or more HIEs, and these strategies are similar to those they proposed to use for EHR adoption—technical assistance and incentives. For example, Rhode Island proposed a multi-payer incentive for providers to enroll in secure messaging and agree to receive alerts when patients are admitted or discharged from the hospital; Texas proposes payer-sponsored payments to providers for HIE connectivity and electronic reporting of quality measures to Medicaid. Targets of efforts to increase provider HIE participation include small, rural practices and smaller or independent laboratories and pharmacies that may not yet have connected.

Many states with less advanced HIE infrastructure would promote provider use of directed exchange (i.e., point-to-point transmission of health information between two entities based on specification from the Direct Project) because it can be scaled more quickly and requires a lower infrastructure investment as compared to query-based exchange. Tennessee also cited the ability to exchange freeform text as the rationale for directed exchange, which stakeholders felt would better meet the needs of some kinds of providers. Enabling the ability to send and receive hospital and emergency room admission, discharge, and transfer information was proposed in multiple Plans within states that do not already have this capability. In states with more advanced HIEs, the Plans proposed the expansion of HIE to include: (1) additional types of data (e.g., medical device data, public health data, outpatient clinical data, claims data), or (2) additional types of providers (e.g., long-term care, behavioral health, public health), (3) interstate HIE connections, and (4) enhancements for complete bidirectional exchange. In addition to increasing provider connectivity to HIE, some states also proposed additional investments in HIE architecture and capacity—for example, transitioning to a centralized, query-based exchange model over the next few years. However, we could not discern from stakeholder interviews or state Plans whether proposed HIE investments were already part of the state's larger health IT strategy or a result of the Plan development process.

Most states would rely on voluntary adoption of EHR and HIE connectivity by providers. In some states, a more aggressive technical assistance and practice facilitation approach was proposed, while other states would use financial incentives to stimulate uptake. For example, Tennessee would use a strategy of rewarding providers when they use health IT. Several states proposed health IT requirements for provider participation in the Plan models, but were not clear on whether the states would use legislative or regulatory authorities for these requirements. For example, Illinois would propose requirements for all Medicaid providers to share patient encounter data with health plans or the state through regional or state HIEs. Both Illinois and Iowa would require participants in their proposed ACO model to participate in the state HIE or a regional HIE connected to the state HIE. Similarly, Maryland would require practices to be able to connect and receive encounter notifications (e.g., admissions, transfers, discharges) as a requirement for certification as a PCMH in its proposed model. Rhode Island, which is unique with respect to having a dedicated state agency to oversee health insurance, proposed using

regulatory authorities to require that value-based contracts between providers and insurers stipulate that providers must use an EHR that meets meaningful use requirements and fully connects to the HIE. Rhode Island also proposed requiring providers operating within value-based contracts to offer HIE enrollment to 90 percent of their patients.

Telehealth. Several states, including Colorado, Hawaii, Idaho, New York, Pennsylvania, and Utah, proposed an expansion of telehealth to improve patient access to care, in most cases building on existing initiatives or prior state plans for expansion, as opposed to originating from the Plan development process. Most states proposing expansion of telehealth would seek to increase patient access to specialty care through spoke and hub models that connect patients in more rural areas to specialists located in larger communities or tertiary medical centers—particularly to increase access to behavioral health services. However, in Idaho, the scope of planned telehealth expansion was broader and included a vision for virtual PCMHs to extend the reach of traditional primary care providers to areas with shortages. In these underserved areas, CHWs and emergency medical service personnel would work with primary care providers and multiple agencies in the region to provide coordinated primary care.

To expand access to telehealth, states proposed several levers. Hawaii proposed changes to malpractice insurance coverage for teledelivered care through state legislative or regulatory change. Pennsylvania intended to pursue grants that would fund telehealth services. Finally, Utah proposed funding expansion of a state university program to provide behavioral health care services through telehealth.

Consumer engagement through technology. A number of states proposed to increase consumer empowerment and engagement in their care through enhanced access to their personal health information, typically through personal health record portals. In some cases, states would promote use of existing consumer Web portals that may be available to patients through their provider's EHR. Other states proposed building a new, centralized, statewide consumer portal to allow any consumer in the state access to his/her own personal health information. The New York Plan, for example, proposed approaches for promoting its in-development patient EHR portal, particularly focused on making it easier for third parties (like health plans or providers) to create tools that would encourage consumers to use the portal. Because Rhode Island law requires that its HIE obtain an opt-in from patients to have their health data exchanged, its Plan also proposed efforts to make it easier for patients to opt in when they sign up for public or private sector health plans, including patient navigators who can assist.

In addition to offering consumers unidirectional access to their personal health information, some of the states proposed additional portal functionalities, including the ability to have secure, bidirectional electronic communication with providers (i.e., secure messaging). Some states also proposed hosting standardized suites of tools to make care more efficient, such as through the use of common new patient intake/history forms and streamlined consent forms

and processes for sharing behavioral health data across providers. Some states also proposed tools to assist patients and providers with health care decision making and care planning, such as standard health risk assessments, end-of-life care planning tools, and patient-directed decision aids.

3.7.3 Data Aggregation and Analytics

Most of the enabling health data aggregation and analytic strategies proposed by states can be categorized as either (1) supporting quality and cost analysis and reporting to support the proposed payment model, or (2) supporting public health, or both.

Quality and cost analysis and reporting. Most of the states acknowledged that the feasibility of implementing some of the proposed value-based payment and delivery models hinged squarely on the collective action of the state, providers, and payers with respect to further investments in the data analytic capabilities. Some states began the Plan development process with existing multi-payer analytic capacity, for example an APCD (see [Table 3-12](#)). In states without an APCD or where planning for an APCD has been slow, many stakeholder discussions during the Model Design process included development of an APCD to support the payment models proposed and several Plans reflected this strategy. In states with existing APCDs, Plans proposed an expansion or additional enhancements necessary to support linking of clinical and payment data and assessment of performance at provider and population levels to support value-based payment models.

Many states (both with and without existing APCDs) described the development of advanced analytic and data visualization tools and reporting architecture for providers and payers with respect to quality and cost performance. Some states proposed a Web portal for provider and payer access to consolidated data warehouses where such tools would be used. In addition, some states proposed that these portals could be used for smaller practices without robust EHR or HIE capabilities to report required quality measures. Two states, Maryland and Washington, specifically proposed to integrate geographic information systems (GIS) with claims data. Utah is creating a Statewide Master Person Index that would allow linking of clinical, behavioral, and APCD information on individuals and assessment of performance (via quality metrics) by providers, ACOs, and public health. Some states also proposed enhancements for their Medicaid Management Information Systems and other state-controlled human service databases to facilitate data consolidation and aggregation. Two states, Idaho and Ohio, both reported that their respective Medicaid Management Information Systems are able to be configured to support PCMH payment models (e.g., tiered PMPM payments), and this functionality may already be in place for states with existing Medicaid-participating PCMH programs.

Table 3-12. Status of state all-payer claims databases in Model Design and Pre-Test states^a

| State | APCD Operational | APCD In Planning or Implementation | No APCD |
|---------------|------------------|------------------------------------|---------|
| California | X ^b | – | – |
| Colorado* | X | – | – |
| Connecticut | – | X | – |
| Delaware | – | X | – |
| Hawaii | – | – | X |
| Idaho | – | – | X |
| Illinois | – | – | X |
| Iowa | – | – | X |
| Maryland | X | – | – |
| Michigan | – | X ^c | – |
| New Hampshire | X | – | – |
| New York* | – | X | – |
| Ohio | – | – | X |
| Pennsylvania | – | X | – |
| Rhode Island | – | X | – |
| Tennessee | X | – | – |
| Texas | – | – | X |
| Utah | X | – | – |
| Washington* | X ^b | – | – |

Abbreviations: APCD=all-payer claims database

^a Source: APCD Council, 2014 <http://www.apcdouncil.org/state/map>.

^b APCD operates as a voluntary, multi-payer collaborative.

^c Michigan has an APCD-like database that supports practices involved in its statewide PCMH demonstration.

* Indicates a Pre-Test state.

X Indicates is present in the state.

Recognizing that such systems take time to build, many states proposed an incremental approach to development. For example, Connecticut planned to standardize specifications for payer analytics, but actual payer data would not be consolidated initially in one system; rather, each payer would retain its own data infrastructure. Most states proposing multi-payer models would allow payers to use their own risk stratification and attribution methods, so the extent to which these types of payer analytics could be housed and provided centrally is not clear.

Public health analytics. Although many states proposed a vision of consolidated claims and clinical data, few reported specific plans for the integration of public health data. Maryland proposed a sophisticated operational management system for its Plan that would use real-time clinical and administrative data from the state’s HIE, GIS information, public health surveillance data, and historical claims data to identify geographic hotspots with health disparities or that represent a disproportionate share of health care utilization; Maryland, in fact, has been working on a prototype system that predates the Plan development process. Similarly, Hawaii proposed to use a more robust data infrastructure to better understand health disparities and work to address them. Pennsylvania proposed to develop a Public Health Gateway for reporting immunization data, cancer surveillance, syndromic surveillance, and required disease reporting (i.e., certain infectious diseases). Delaware and Washington proposed to expand their HIEs to accommodate public health data, and New York proposed to include population health measures such as weight, birth outcomes, and HIV diagnoses in the quality measure dashboards that would be used to monitor PCMH performance. Likewise, Utah proposed to make its clinical HIE a viable platform for reporting both individual providers’ quality metrics and as a platform for reporting community quality metrics. Lastly, Connecticut would integrate public health data into an integrated data warehouse designed to support the proposed delivery and payment model as part of the final phase of development.

3.7.4 Public Health

Public health strategies involve activities to improve health of populations that are not specifically patients of any one provider or payer. In contrast to a delivery system model of care, public health strategies are delivered outside the health care delivery system to the general population. Often, a non-health care provider is responsible for promoting public health strategies, and in some cases, is the backbone organization to a defined coalition for health or accountable community for health. Common goals of public health strategies are to improve heart health, tobacco cessation, and to reduce obesity in the general population—either through community-based activities, or through closer relationships between clinical health care providers and non-health care organizations (such as social services, schools, community development organizations, transportation, parks and recreation agencies, and civic groups).

Twelve of the 19 states’ Plans proposed to expand existing strategies or establish new entities that would address community health needs outside the clinician-patient relationship (California, Connecticut, Idaho, Illinois, Michigan, New York, Pennsylvania, Rhode Island, Texas, Utah, Washington); and two states (Iowa, Maryland) would leverage those entities that already exist. Some of these states highlighted activities that build on traditional public health functions (such as health planning and prevention services) done by existing agencies, whereas at least nine states have or are in the process of creating new entities charged with improving community health.

One example of extending traditional public health functions is in the Pennsylvania Plan, which proposed a new State Health Improvement Plan process run through its Department of Health with stakeholder input. This process, to begin in 2014, would set forth mechanisms by which public health and health care delivery systems could be better coordinated. Pennsylvania also proposed to begin using GIS mapping for chronic disease surveillance. Similarly, the Rhode Island Plan identified an opportunity to advocate with state, city, and town planning entities for incorporating consideration of the impact their policies have on population health. Rhode Island also proposed to create a fund to improve Rhode Islanders' access to prevention services such as vaccines, tobacco cessation programs, obesity prevention, and other disease-specific efforts, regardless of payer. Similarly, the Hawaii Plan proposed to pursue a "health in all policies" approach. Finally, the Texas Plan identified opportunities to expand existing programs to improve diabetes self-management services, and the National Diabetes Prevention Program (focused on preventing the onset of diabetes) for Medicaid enrollees.

The majority of states that proposed to address health needs on a community level have designed new regionally based entities that would have some degree of responsibility for improving community-wide health measures. Most of these entities share key features: they are voluntary coalitions of private, multi-sector—and sometimes local public health—organizations, but with one "backbone" or host organization; they would have access to enhanced data analysis that helps target opportunities for health improvement by the health care delivery system, by other non-health system policies, or both; and they would promote evidence-based public health policies. *Table 3-13* compares the names and intended role of these entities in the nine states that proposed them.

Maryland already has 18 Local Health Improvement Coalitions in place, which are public/private coalitions that receive funding support from the state, hospitals, and grants from the Centers for Disease Control and Prevention; similarly, Pennsylvania has 21 existing Health Improvement Partnership Programs registered with the state. California, Connecticut, Illinois, Michigan, and Utah planned to pilot this concept in one to three communities. By January 2015, Washington expected to certify these entities in three regions. Although the Idaho Plan suggested that Regional Collaboratives in that state would support public health and local organizations' efforts to conduct health needs assessments and wellness activities similar to entities in other states (as part of their work supporting primary care practices), the Plan did not position the use of these organizations as a public health strategy.

Several states proposed mechanisms by which community organizations and accountable entities would work together to achieve local public health goals. In Washington, this organization would be one of nine regional ACHs, which would be responsible for oversight of the ARBEs in addition to creating a Regional Health Improvement Plan, coordinating to develop compacts across service providers to meet its goals, and facilitating workforce resource sharing. Illinois also proposed development of regional hubs to coordinate public health planning on a

regional level; but the concept of how the accountable entities would interface with these hubs suggests a looser coordination than in other states also proposing an approach based on accountable entities (e.g., Washington and Michigan).

Table 3-13. Names and intended role of entities to improve community health

| State | Name of Entities | Primary Community-level Strategies | Also Support Health Care Providers? |
|--------------|--|--|---|
| California | Accountable Care Communities | Set goals and metrics of success, monitor data, focus interventions on populations with demonstrated health disparities | No |
| Connecticut | Health Enhancement Communities | Implement evidence-based interventions (policy, systems, or environmental) to address tobacco use, nutrition, physical activity, and diabetes care; focus on areas with health disparities | No |
| Delaware | Healthy Neighborhoods | Coordinate across health care and community organizations, set goals and create action plans, monitor progress | No |
| Idaho | Regional Collaboratives | Collaborate in local health needs assessments and implementation of wellness and quality improvement initiatives | Yes |
| Illinois | Regional Hubs | Use enhanced data analysis, evaluate and promote community health interventions | No |
| Iowa | Blue Zones (existing) | Change policy, environment, and social networks to improve health | No |
| Maryland | Local Health Improvement Coalitions (existing) | Monitor progress on health outcome measures; integrate public health and delivery system efforts | Yes, if selected to become a new Community Health Hub |
| Michigan | Community Health Innovation Regions | Conduct collaborative community needs assessment; prioritize and promote evidence-based interventions; address social determinants of health. | Yes |
| New York | Regional Health Improvement Collaboratives | Regional health planning to promote New York's Prevention Agenda, linking primary care with community resources | Yes |
| Pennsylvania | Health Improvement Partnership Programs | Address priority topics identified in the State Health Improvement Plan; implement policy, systems, and environment change to improve health | No |
| Utah | To be determined | Develop a common health agenda for the community, data analysis, evaluate and promote best practices | No |
| Washington* | Accountable Communities (now Collaboratives) of Health | Develop a Regional Health Improvement Plan; oversee accountable risk-bearing entities in their region; advise on Medicaid procurement in the region; analyze and communicate data | Yes |

* Indicates a Pre-Test state.

3.7.5 Infrastructure to Support Delivery System Transformation

Infrastructure to support delivery system transformation includes organizations and policies to provide technical assistance to practitioners. The focus of this assistance may be on the transition to a medical home, adoption of team-based care, improvement on certain health or cost outcome aims, integration with community resources, and readiness to participate in value-based payment models.

Fourteen of the 19 states proposed to establish an infrastructure external to the traditional health care delivery system that would provide practice transformation training and other technical assistance. For example, four states proposed public-private partnerships whose sole purpose would be to cultivate ongoing learning opportunities and sharing best practices across health care providers: Innovation Transformation Resource Center (Illinois), the Rhode Island Care Transformation and Innovation Center, the Health Innovation Learning Network (Texas), and the Transformation Support Regional Extension Service (Washington). In four states, the same organizations would be responsible for providing training to help health care providers and others adapt to new delivery system and payment models and would foster connections between health care and non-health care services: Colorado (the Health Extension System), Delaware (Center for Innovation), Idaho (Regional Collaboratives), and Pennsylvania (Transformation Support Center coordinating training and 7 to 10 regional hubs that would offer both coaching and coordination to providers). Such centers would provide states with assistance obtaining recognition (e.g., PCMH recognition) for participation in new payment models. Some states' Plans would also task these entities with providing support to the health care delivery system through workforce or HIE coordination. In addition to assistance from new organizations, states proposed a range of other supports to providers. Washington proposed to develop and certify decision-making tools for providers on three topics—maternity care, end-of-life care, and joint replacement. Similarly, Texas would support providers to participate in existing diabetes management recognition programs.

Seven states proposed mechanisms through which health care providers would receive support in referring patients to—and coordinating with—social supports in the community. In two of these states, the mechanism would be a set of personnel in the community who play this role: community health teams in Rhode Island and CHWs in Delaware. The New York and Rhode Island Plans also specified, respectively, the use of community resource registries and comprehensive resource directories as tools to facilitate these linkages. Pennsylvania Medicaid proposed to fund Community-based Care Management teams that would work within their providers (and some FQHCs) to address services for the 5 percent of Medicaid enrollees with the most highly complex physical and behavioral health and social service needs.

In five states, a designated organization would take a lead role in partnering with health care providers to offer these services. For example, the Connecticut Plan described Designated

Prevention Service Centers that would offer primary care practices a credible source for evidence-based preventive services to which they could refer patients. These Prevention Service Centers would begin with offering the Diabetes Prevention Program, Asthma Home Environment Assessment Programs, and a Falls Prevention Program. The Maryland Plan described community health hubs that would provide community-based interventions to specific populations identified through claims and clinical data analysis. In the three pilot Community Health Innovation Regions (CHIRs) in Michigan, consortia of organizations would help providers integrate clinical, behavioral, and social services and ACO-like entities would be required to participate in these CHIRs. In New York, Regional Health Improvement Collaboratives would strengthen linkages between primary care providers and community resources. Finally, in Washington, ACHs would offer help to providers in creating service compacts and sharing workforce resources with one another.

3.7.6 Consumer Engagement

Consumer engagement strategies describe activities intended to change consumer/patient behavior to become more involved in their health and health care decision making. These activities include promoting patient-centered communication; changing the clinical setting to activate patients in their own care, such as providing access to their health information; and promoting choice architecture within insurance plans to help consumers choose the highest-value health care services (e.g., value-based insurance design, or VBID). Seven of the 19 states emphasized the role of consumer engagement in facilitating health improvement or health care delivery system change. Three states (Connecticut, Iowa, New York) proposed to expand or initiate VBID to change consumer incentives for healthy behavior. The Connecticut state employees' health plan already has a VBID component, lowering premium costs for employees and retirees who voluntarily choose to comply with a minimum schedule of well visits and screening and chronic disease education programs when relevant. Other large self-insured employers in the state also have VBID, and under the Connecticut Plan additional health plans and employers would voluntarily adopt this approach. The Connecticut Plan also proposed a model for providing employer-funded incentives to employees to purchase foods high in nutrition, but did not describe how such a program would be designed or implemented. Similar to Connecticut's approach, the New York Plan proposed to consider an opt-in VBID model in its state employee health plan. In addition, the New York Plan suggested steps the state could take to encourage payers to adopt VBID approaches, such as defining VBID in regulation and potentially including VBID as an element of rate review for health insurers. Finally, the Iowa Plan proposed to incorporate a VBID element directly into the new ACOs they would contract with to serve individuals not eligible for Medicaid but living below the federal poverty line. These ACOs would also eliminate financial contributions for participants who meet required wellness activity goals.

Six states (Connecticut, Delaware, Hawaii, New York, Rhode Island, Utah) proposed to engage consumers by making information related to health and health care more readily available. In Connecticut, this would include information on shared decision making with providers and quality, cost, and price information. Similarly, New York proposed to develop a Web site referred to as a consumer-oriented transparency portal to make a core set of quality, utilization, and cost metrics at the facility and practice levels available to the public. The Delaware Center for Innovation would be responsible for: (1) developing a common scorecard to track the progress of providers across cost and quality performance and outcomes measures, and making those results public; and (2) giving patients better access to information and resources (e.g., disease management tools, information about local health services). Utah proposed to conduct a public education campaign about choices in end-of-life care, to support provider education and tools on that topic. The Hawaii Plan indicated that the state would include consumer-facing educational materials about disease prevalence and self-management on the same Web site where it would post health care quality and cost data. Finally, Rhode Island also proposed to implement a navigator program, similar to the one used in its state-based health insurance marketplace, to assist patients and consumers with their health needs and navigation of the new value-based care delivery system.

Two states proposed to engage consumers using new health IT capacity. Both New York and Rhode Island would encourage consumers to gain access to their EHR.

Finally, the New Hampshire Plan proposed to expand its current Medicaid program under the CMS-funded Money Follows the Person program. Through consumer-directed purchasing of LTSS, New Hampshire would support changes in LTSS provider capacity.

3.8 Summary of Findings

In this section, we summarize findings with respect to state context, planning process, stakeholder engagement, models considered, enabling strategies, policy levers, and potential for implementation.

3.8.1 State Context

The 19 states have diverse geography, laws, regulation, approaches to policy-making, health care markets, workforce capacity, and infrastructure to support their health care systems—leading to a different Plan design and roadmap to SIM objectives in each state. This finding is not entirely unexpected and in many ways reflects the goal of the Model Design process, which was for states to design transformative statewide models for health care delivery and payment that are acceptable to state stakeholders, are feasible to implement within the state, and consider unique state circumstances. A major contextual factor that seems to have influenced the types of models included in a state’s Plan is whether the state already had some level of experience with the proposed model through Medicare, its Medicaid program (e.g., through waivers), or a

dominant commercial payer. Several states with a more competitive market cited difficulty engaging national payer stakeholders. The readiness of a state with respect to HIE and data infrastructure and analytics to support new delivery and payment models did not influence the models that states included in their Plans, although it could affect the distribution of SIM funds under a Model Test award. The latter was not within the scope of this evaluation.

3.8.2 Planning Process

All states used a planning infrastructure involving state leadership either at the Governor's Office level or state agency level. Most states involved contractors to support the planning infrastructure, which often included nongovernment stakeholders organized into advisory boards, work groups, committees, or task forces. The number of work groups and meetings held varied greatly among states, and some states used more open processes than others. Contractors provided significant logistical and facilitative support for meetings and helped draft the written Plan in many states. In addition, some contractors provided significant content expertise to the state and to the state's work groups as different models or approaches were discussed.

In all but a few states, stakeholders generally agreed to the Plan put forward by the state. However, this agreement was largely qualified as agreement with the concept, but not necessarily an agreement to participate in the models or activities proposed—because stakeholders did not have the level of detail they felt they needed to make firm commitments or because they were not convinced the Plan would actually move forward. But, in most of these cases the process ended with commitments to continue to work on refining the Plan or developing the specifics needed to put the Plan into action.

Additionally, in many states, SIM leaders managed the short planning period by presenting initial proposals to kickstart discussions. In some cases, stakeholders viewed this approach as constraining and not very collaborative, while in other cases this approach was acknowledged as the only feasible way to get the task of developing a Plan done within the allotted time.

Finally, the short time frame for planning exacerbated other challenges faced by the states. For example, one state had turnover in SIM leadership, which resulted in a somewhat compressed time frame for planning.

3.8.3 Stakeholder Engagement

Most states used their award to reach a broad range of stakeholders through both formal and informal channels. States had varied success with engaging the broader payer community beyond Medicaid, Medicaid-contracted MCOs, and state employee health plan administrators. Stakeholders in several states commented that health insurers with mostly commercial lines of

business were present at meetings, but did not always participate vocally. In fact, the SIM Model Design planning process identified several barriers to participation among the payment community, such as nationwide companies' reluctance to engage in state-specific quality measurement efforts. As a result, nonpayer stakeholders expressed skepticism at the level of commitment from these payers, and payers themselves noted that the models and strategies discussed during the planning meetings did not always contain enough detail to evaluate their feasibility or comment on the degree to which payers could implement them.

In several states, stakeholders other than state officials, payers, hospitals, and physician groups had a significant influence on their state's Plan, either because they were involved in the process by initial design or because the planning process left the door open for them to join in. These stakeholders were pediatricians, behavioral health care providers, public health officials and advocates, health equity experts, and advocates for persons with developmental disabilities. CMS's efforts to broaden states' perspective beyond the physical health care system and consider social determinants of health reinforced the importance of considering many of these stakeholders' inputs.

Finally, the degree to which states engaged consumers or their representatives also varied. Some states used focus groups, town hall-style meetings, and Web-based comment boxes to solicit feedback. Connecticut added independent consumer representatives to its Steering Committee partway through the planning process—one of the few examples of incorporating consumers in a bidirectional deliberation.

3.8.4 Health Care Delivery and Payment Models

PCMH/health home models were the most commonly selected among states that promoted statewide changes to their state's health care delivery system. This is perhaps not surprising because the PCMH model has been implemented in many states already; several organizations offer formal PCMH recognition programs using standardized criteria, and there is a growing body of evidence for what effects PCMH has on provider and patient outcomes. In contrast, the concept of an ACO is relatively new (McClellan et al., 2010), the definitions of what constitutes an ACO vary across payers and states, and stakeholders in several states questioned whether there is sufficient evidence for ACOs' results with regard to patient and financial outcomes. Similarly, evidence is lacking on episode-based payment models, and they require significant technical expertise and analytic capacity on the part of payers to implement.

Although most states developed variations in one or more of three innovative delivery and payment system models (PCMHs/health homes, ACOs, EOCs) in their Plans, other delivery system enhancements emerged in the areas of behavioral health care, LTSS, maternity care, end-of-life care, and care for medically or socially complex patients. These enhancements

supplemented the proposed models in the state, or stood as complementary but parallel changes to address specific areas identified through stakeholder processes.

3.8.5 Enabling Strategies

All states proposed enabling strategies that would support transformation of the health care delivery system to one that could accept value-based payment and deliver high-quality health care for lower cost. These strategies generally aim at enhancing the infrastructure available to health care providers, health insurers, and consumers that support care delivery and the flow of information. All states' Plans included workforce development and health IT strategies; other proposed enabling strategies involved data aggregation and analytics, public health approaches, training and organizational infrastructure to support delivery system transformation, and consumer engagement in health care.

Some of the infrastructure proposed builds on existing, familiar initiatives in states, such as support for EHR implementation, statewide or regional HIEs, or an APCD. For example, increasing the use of health IT is a common strategy to improve coordination of care for patients across health care providers, on the assumption that making more health information electronic at the point of care (via EHRs) and transferring that information (via HIEs) will create the conditions in which providers have more complete data with which to make diagnosis and treatment decisions. In some states, clinical data from EHRs aggregated through a query-based HIE was the source envisioned for determining a provider's performance on a common set of quality measures, regardless of payer. In other states, a new or developing APCD was proposed as the source for quality calculations, total cost of care, and efficiency metrics, on which payment models would be based.

However, some proposed infrastructure would be entirely new for some states, such as a new organization that would serve as a resource center to providers transitioning to a PCMH, ACO, or other delivery system model that requires retraining providers in delivery care through more integrated, team-based efforts. Additionally, in some states, traditional public health functions were identified as part of the infrastructure necessary to help health care providers achieve population health goals. New organizations or new roles for public health departments were incorporated into states' Plans to conduct health care workforce planning, health needs assessments, community-based health education and promotion interventions, and health surveillance—and in some cases, proposals were included to link funding for these functions with funding for the health care delivery system.

Most enabling strategies focused on building infrastructure within the control of health care and public health professionals. Some states turned to a potentially more potent but less predictable mode for creating health system change—influencing consumer behavior. Fewer than half the 19 states proposed one or more of these strategies for greater consumer

engagement: promoting shared decision-making, education about choices in end-of-life care, providing incentives for adhering to certain health care screening and chronic disease education regimens (through VBID), and making the patient an active participant in his/her health through more complete access to his/her health information.

3.8.6 Policy Levers

Even states that proposed similar models or enabling strategies in their Plans—and had similar goals for health care delivery and payment system change—identified different policy levers to achieve their vision. This occurred for three main reasons. First, the diversity in laws, regulation, and approach to policy-making across the states yields a different roadmap for Plan implementation in every state. For example, states with a robust regulatory mechanism for reviewing health insurance plans (e.g., New York and Rhode Island) proposed to use that lever to align payers around a common delivery system and payment model. However, many other states still proposed multi-payer alignment without identifying the need to increase regulatory authority of health insurers; instead, in these states, political pressure or state facilitation are predicted to make change occur.

Second, in some states the roadmap for Plan implementation included removing barriers to enacting some of the proposed changes. For states that needed to change rules about the types of providers with which Medicaid could contract, or rules about co-location of physical and behavioral health care providers, the most important policy levers related to undoing existing policy specific to that state.

Third, states' Plans left some policy levers to be determined, either because they avoided a potentially controversial topic intentionally, discussed it but did not have the stakeholder consensus to support a clear policy lever to force change, or believed that voluntary agreement would be sufficient for widespread implementation. For example, many states proposed establishing a common set of quality metrics that all payers would use in value-based purchasing arrangements with providers, to better align providers toward improving performance on those metrics. However, most stakeholders cited that parts of the Plan are less feasible to implement, on the basis that achieving agreement across health care payers would be unlikely. Despite these stakeholders' pessimism that their states' policy environment was not amenable to common quality measures—perhaps the lynchpin of many states' Plans—the planning process produced optimism that voluntary agreement to the Plan itself may be sufficient.

3.8.7 Potential for Implementation

Most states' Plans identified additional federal funding—through a Model Test award or other grant funding—as an important factor facilitating implementation of the proposed models and enabling strategies. Many states planned to use this additional funding to support the proposed enabling strategies, particularly those having to do with providing technical assistance

and support for delivery transformation, and for the HIE and data infrastructure and analytics capacity to support the new delivery and payment models. Most states considered some aspects of the Plan as feasible in the absence of a Model Test award or additional funding; typically these were components involving Medicaid, Medicaid MCO, or state employee health reforms, which are clearly under the control of the state. However, most states acknowledged that the scope and timeline for implementation would be less certain in the absence of additional funding. Although many states identified additional funding as necessary to support some of the data aggregation analytics necessary for multi-payer and value-based models, voluntary cooperation among payers and providers appeared to be the more critical factor in determining feasibility of implementation in most states, and the extent to which states were able to secure this agreement during the Model Design process varied.

In summary, all Model Design and Pre-Test states engaged a diverse set of stakeholders in their planning process, using a variety of approaches and resulting in a range of stakeholder response. With few exceptions, the models considered generally hewed to the familiar types: PCMH, Section 2703 Health Homes, accountable care, and episodes of care payments. States also proposed a variety of enabling strategies in the areas of workforce development, health IT and data infrastructure, and facilitation of delivery transformation in support of these new models. Although many states would leverage their role as purchasers to drive adoption, voluntary cooperation among payers and providers would be relied on in most states; in many cases this cooperation would depend on further specification of the model. Additional funding would be necessary for Plan implementation in most states.

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4. Lessons Learned

As part of the State Innovation Model (SIM) Model Design and Pre-Test Evaluation, we asked stakeholders about lessons learned during the Health Care Innovation Plan development process and any recommendations for future efforts by the Centers for Medicare & Medicaid Services (CMS). This section provides a summary of those responses.

4.1 Common Lessons Learned Across Model Design and Pre-Test States

The interviewees identified lessons on leadership, stakeholder engagement, time and resources, the process, and the Plan. Lessons that were common across multiple states are listed in [Table 4-1](#) and briefly described by topic area below.

Table 4-1. Lessons Learned

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|---|
| <p>Leadership</p> <ul style="list-style-type: none">• The state is an appropriate and necessary, but not sufficient, leader of health care transformation.<ul style="list-style-type: none">— The Governor’s support provides visibility and gives stakeholders confidence that time spent in the planning process will not be wasted.— The state can leverage its role as a payer for Medicaid and state employee coverage to be a “first mover” toward health care transformation and thereby build momentum for transformation.— The state’s reach is limited, so it must build partnerships with private and other public sector stakeholders in support of the Plan.• Strong leadership can help engage stakeholders in the process.<ul style="list-style-type: none">— Leadership should have ongoing access to the Governor’s policy advisors to assure stakeholders of the value and high visibility of the initiative.— Private meetings and calls to stakeholders from leadership can help open lines of communication, identify issues, and assure stakeholders their views will be heard.— The leadership should keep the process focused without being prescriptive. <p>Stakeholder engagement</p> <ul style="list-style-type: none">• Input from all affected stakeholders should be sought early and often.<ul style="list-style-type: none">— Early engagement provides stakeholders the time to develop and provide feedback on multiple iterations of the Plan.— Stakeholders may need upfront education on existing services and new models of care and payment methods.• The type of stakeholders included in the plan development process can determine its design.<ul style="list-style-type: none">— Cast a wide net when identifying stakeholders.— Some models may require specific expertise (e.g., payment for episodes of care requires knowledge of the specific disease, treatment options, and management guidelines).— Additional effort may be needed to incorporate representation from consumers and patients.• Stakeholders can be energized by giving them both responsibility and authority.<ul style="list-style-type: none">— Involvement of the Governor and other high-level state officials can help engage stakeholders in positions of authority.— Work group participation allows a variety of stakeholders to be involved in a meaningful and productive manner. |
|---|

(continued)

Table 4-1. Lessons Learned (continued)

Time and resources

- **The time frame for planning ultimately dictates the process used and the innovation and detail in the resulting Plan.**
 - A fully open, participatory process is difficult to conduct during a constrained timeline.
 - Building consensus or common understanding takes time.
 - A condensed time frame will likely result in a Plan based on the expansion or enhancement of existing initiatives, with few novel or controversial ideas.
 - With a shorter time frame, fewer details of the Plan will be ironed out during the planning phase.
 - A short time frame helps keep participants focused and engaged.
- **Having the right resources can make a difference.**
 - Having a team of staff dedicated to the transformation effort is crucial.
 - Use of outside consultants and contractors can bring valuable subject matter expertise, logistical support, and external perspectives.
 - The prospect of SIM Model Test funding made broad implementation seem feasible and brought key stakeholders to the table.

The process

- **Front-end planning can be critical.**
 - Upfront logistical planning can facilitate the difficult and time-consuming job of convening meetings with a large number of participants.
 - Upfront data gathering and synthesis can help prepare stakeholders to discuss the complex issues of health care reform.
 - The costs and returns associated with different strategies can be instrumental.
 - Availability of information on any particular model can affect whether it is considered or chosen for inclusion in the Plan.
- **Communication is key.**
 - Effectively managing the communication process is challenging and time-consuming but integral to the success of the planning process.
 - Stakeholders should be kept apprised of the process and plan elements.
 - Tailored communication tools and methods may need to be developed and used with different stakeholder groups.
 - Communicate early and often.
- **Help stakeholders focus on the common goal.**
 - Efforts to pursue system-level reform require stakeholders be team players.
 - Building trust and aligning incentives among stakeholders may need to occur before real collaboration can occur.
 - Successful planning needs to combine technical expertise with real-world savvy and political influence.

The plan

- **Build on existing models, but make room for innovative approaches.**
 - Build on existing models in the state that have evidence of yielding success early on and use them as part of the argument for moving forward with a bigger initiative.
 - Allow for the submission, discussion, and integration of novel, innovative ideas into the Plan.
- **A trade-off exists between obtaining broad consensus on a Plan and providing details on how to implement it.**
 - Building consensus is valuable, but time-consuming.
 - Find the highest level of agreement across stakeholders and then work down.
 - Working within a broad population framework can help engage a range of stakeholders.

4.1.1 Leadership

Most interviewees saw the state as an appropriate and necessary leader of an effective health care transformation planning process. The Governor's support makes the SIM Initiative visible and provides the credibility needed to engage stakeholders in the process. Furthermore, the state as a major payer and regulator in the health care market yields significant power and influence to make reform happen. Interviewees noted, however, that the state's reach is limited and that the design and implementation of a state-led health care transformation effort faces several challenges. For example, gaining the cooperation of national insurance carriers may be difficult because they must balance the demands of multiple states. The state must also align its activities with federal Medicare payment and delivery reform efforts. Thus, although the importance of state leadership is generally supported, many interviewees noted the need for a health care transformation governance model that is not dominated by the state but rather one in which the state is part of a partnership. To achieve a statewide reach and touch a preponderance of the population, the state must seek a partnership with both state-based and national private and other public sector interests in developing a plan to transform health care.

Interviewees also noted that the state is only as effective as the leadership guiding its planning process. The role of leadership in securing buy-in for the state's vision was generally recognized. In more than one state, interviewees credited good leadership with helping engage stakeholders in the planning process. To assure stakeholders of the value and importance of their participation, interviewees recommended that leadership have visible, ongoing access to the Governor or his/her policy advisors. Several interviewees noted that private meetings and calls to stakeholders from state leaders helped open lines of communication, identify issues stakeholders were reluctant to raise at meetings (e.g., payment issues), and assure stakeholders their views would be heard. To maintain interest and engagement, interviewees recommended that the leadership convene and guide stakeholders through the Plan development process without taking it over—that is, they should keep the process focused without being prescriptive.

4.1.2 Stakeholder Engagement

In general, interviewees believed that failing to include all affected stakeholders from the beginning of the planning process would affect Plan design and may reduce buy-in and encumber Plan components that rely on voluntary actions during implementation. Early and meaningful engagement of stakeholders allows them time to develop and provide feedback on multiple iterations of the Plan.

Interviewees noted the challenge of balancing a more open approach to Plan development with an approach employing a smaller, tighter decision-making group. A smaller group may be more nimble and efficient, but may require redirection midstream because of the lack of buy-in across all relevant stakeholders. Most interviewees supported inclusion of a broad, diverse group of stakeholders but noted both pros and cons of this approach. In several cases, inclusion of

additional stakeholder groups had a significant impact on Plan design. In Utah, for example, adding behavioral health representatives to work groups changed the discussion greatly; initially behavioral health was not even on the table, but it became one of four major components of the state's final Plan. Similarly, establishing a population health task force to engage individuals in public health fields in Illinois enhanced proposed strategies for improving population health outside the traditional health care system. These post-award changes in scope were viewed as improving the outcomes of the planning process.

However, inclusiveness may come at the expense of added time and resources and a Plan that is unfocused or favors one group over others. Considerable planning time may need to be spent upfront educating stakeholders on existing services and new models of care so they understand the options. For some models, specific expertise may be needed among work group members. For example, development of payment models for target episodes of care requires expertise on the disease, treatment options, and management guidelines. In addition, with a more open process many more ideas may be put forth, making the discussions more diffuse and potentially preventing development of a focus around a feasible and practical strategy. On the other hand, an open process, in which any citizen can participate in work groups and stakeholder meetings, can sway decisions in favor of a stakeholder group with a large active membership relative to a group with less representation.

Not only the type of stakeholders but the position and clout of the participating stakeholders matters. Interviewees noted that the involvement of the Governor and other high-level state officials can attract high level and active participation in the SIM planning process from key stakeholders. In addition, the right level of stakeholders can be energized to engage in the Plan development process by giving them responsibility and authority. Most states set up work groups of public and private sector stakeholders to develop the Plans. Work group participation allows a variety of stakeholders to be involved in a meaningful and productive manner.

When asked about the adequacy of the stakeholder engagement process, many interviewees noted too few members whose function was to represent the patient voice. Most states that restricted participation in the Plan development process, however, did conduct parallel outreach to the public through listening sessions around the state, solicitations for public comment, and public presentations. Because a public and transparent process is essential, states need to develop procedures that ensure consumer and patient input and buy-in.

4.1.3 Time and Resources

Several state officials and other stakeholders commented on the impact the short time frame for the Model Design phase had on the process and resulting Plan. Interviewees noted that the 6- to 8-month time frame required an intense effort and discouraged participation among

stakeholders who could not balance the required intensity of the process with their organization's other priorities. Others related that the time frame was too short to gather and synthesize information on successful reforms in other states; develop a common understanding around the charge of their work group; develop the needed collaboration among health systems, payers, and community-based providers; and build the desired consensus. Stakeholders in several states noted that to develop a Plan in the allotted time frame required that they start with either a "straw man" proposal (i.e., an existing initiative or model that could be expanded or a novel model that had already been vetted in a prior initiative within the state or another state). These interviewees indicated that the result was a Plan that incorporated mostly ideas known to stakeholders and few innovative ideas. In addition, many Plans were merely frameworks for a transformation model and included few details on how the Plan would be implemented. In defense of the short time frame, interviewees noted that it instilled a sense of urgency and kept the participants focused without wearing them out—that a lengthy process could have diminished the momentum.

Besides time, stakeholders noted that the right resources contribute to the success of the planning process. In at least one state, having a state team dedicated to the transformation effort was critical for convening the extremely high number of meetings and individual conversations required of the effort. Stakeholders in another state noted that the level of effort required to develop the Plan was only met through the many in-kind hours expended by volunteer work group leaders; for some leaders, this donation of time was onerous. The SIM Model Design funds made it possible for states to hire consultants and contractors. Use of outside consultants and contractors for subject matter expertise, logistical support, and an external perspective was generally viewed as a valuable supplement to state staff. The prospect of future SIM Model Test funding also helped the Model Design phase—it made broad implementation seem feasible and brought key stakeholders to the table.

4.1.4 The Process

Stakeholders found front-end planning to be critical because the logistics of convening meetings with a large number of participants is challenging, the issues addressed are complex, and the time frame within which decisions must be reached is limited. Of particular importance was gathering information on other payment and delivery system reform efforts both within the state and in other states, as well as the costs and returns on investment of different strategies. Once gathered, this information must be prepared for presentation to stakeholders in an understandable and unbiased manner. Stakeholders in more than one state noted that the lack of material presented on models other than the one being promoted by the state made it difficult for them to make a case for a different model.

Stakeholders identified effective communication as another critical element. They noted many challenges related to communication. Each state had a number of work groups, task forces, and committees addressing different issues, models, or strategies. Effectively managing

and coordinating the flow of information among these entities was seen as essential for creating buy-in and designing a strong transformation plan. Of particular importance was keeping stakeholders apprised of the planning process and proposed plan elements. This was seen as particularly challenging, because the concepts and models are complex and stakeholders vary widely in their background, knowledge, and training. Thus, communication may need to be tailored to the stakeholder group. In addition, as one stakeholder noted, “there’s no such thing as over-communication” and advocated that the state “spread the word early and often.”

Efforts to pursue system-level reform require that stakeholders be team players and keep an eye on the common goal. When stakeholders focus too narrowly on their own agendas and do not think broadly, tensions can rise and progress can slow. Stakeholders noted that states without a history of collaboration may need to build trust and align incentives before the real collaboration needed for the planning process can occur. Most collaboration will start at local and regional levels before it occurs at the state level.

Alternative approaches to the development of public policy put differing emphasis on soliciting recommendations from outside experts and responding to grass roots politicking by advocacy groups. Relying entirely on outside experts may produce technically expert plans that lack political viability or are difficult to implement, whereas a wholly political approach may have legislative clout but questionable technical merit and little practicality. Thus, successful planning needs to combine technical expertise with real-world savvy and political influence.

4.1.5 The Plan

Given the short time frame and complexity of the task, and with encouragement from CMS, many states built their Plans on existing models within the states. Stakeholders are familiar with the models, increasing the likelihood of their support, and the models are more likely to yield success early on. The states could then use the success of these programs to argue for moving forward with a bigger initiative. Stakeholders noted, however, that starting the development process with an existing framework can substantially influence the final Plan by discouraging innovation.

Another common theme from the interviews was that, although the draft Plans may have a clear vision for health care redesign, they lacked detail. A Plan or model cannot be implemented without specific components; stakeholder buy-in will depend greatly on the inclusion or exclusions of certain components. Health plans and provider stakeholders in several states noted that whether their organization would be involved in implementation or support all aspects of the Plan depends on such details.

Thus, consensus is not only a good thing, but necessary for Plan implementation. However, as many stakeholders noted, a trade-off exists between obtaining broad consensus on a Plan and providing details on how to implement it. Furthermore, consensus-building takes time,

and agreement at the highest level is often easier than at the lower detail level. To reach consensus, interviewees recommended that stakeholders identify their concerns as well as where they agreed, and that the goals of the process be clear from the outset. One state found that working within the broad framework of population health spurred interest and participation by a broad group of stakeholders.

4.2 States' Recommendations for CMS

Many states commended CMS and the federal government for providing the SIM opportunity. Stakeholders and state officials alike felt that the external funding and facilitation from CMS were vital for the success of the planning process. They appreciated a funding opportunity for planning which stressed innovative approaches to health care transformation that could be tailored to their states. Along with the funding, federal endorsement of the health care transformation planning process helped the state bring stakeholders to the table. One official in a state that had already been considering payment innovations noted that the SIM Model Design award allowed the state to systematically discuss key elements of its efforts, such as workforce and health information technology (health IT), that it would not have otherwise been able to do.

Although stakeholders and state officials in the Model Design and Pre-Test states were appreciative of the SIM awards, they had several recommendations for improving the Model Design process. A synthesis of the recommendations common across multiple states include the following:

- **Be more specific about the required elements of the proposed models.** Some states were confused by early communication from CMS around the scope and focus of the Plan. For example, one state representative said the requirement for the Plan to reach 80 percent of care was clear to all stakeholders involved, but stakeholders outside the planning group were not clear whether shared risk/savings was a required element. Several states requested clarity from CMS around specific elements they see as crucial for successful health system transformation, such as health IT and health information exchange, consumer engagement, and transparency. In such cases, the stakeholders felt the state may have been open to these strategies, but without a minimum bar or clear expectations set by CMS, these important issues did not always take priority. Not all state officials wanted more expectations or requirements from CMS, however. Officials in at least one state felt blindsided by the emphasis on reaching 80 percent of care in the state after they were committed to a narrower focus for the SIM Initiative. Other states perceived the CMS project management process to be too prescriptive—introducing requirements not in the solicitation and making innovation more of a top-down than a bottom-up process, especially the selection of issues to be addressed.
- **Provide enough flexibility to design models that work best for the state.** Stakeholders recognized the Patient Protection and Affordable Care Act as a large strategic program for transforming health care in the nation, but believed it would not

work well unless the states were empowered. They believed that the more flexibility CMS could give the states the better in terms of a state's ability to complement the SIM Initiative with other health care innovations ongoing within the state.

- **Require that states involve their public health resources in the planning process.** Stakeholders in multiple states requested that CMS require states to involve their public health resources in the planning process in a meaningful way. A stakeholder in one state noted that payers and providers do not feel the urgency of population health issues and recommended that CMS push or clarify the minimum level expected of states in this area.
- **Be more flexible and quicker to approve budget modifications.** One state asked for greater flexibility in budgeting the award funds, noting that the addition of a subcontractor to conduct focus groups resulted in the contractor not being paid. Another said that budgetary modifications need to be approved on a faster schedule. An official for that state commented that as the state's plans changed over time so did their budget needs, resulting in multiple requests for budget changes.
- **Medicare needs to be at the table, just to listen, if nothing else.** Several states noted the absence of a Medicare presence at the table during the planning process and argued that this absence creates issues both with stakeholder expectations and with the reach of the initiative to transform care. One state official noted that it would have been helpful to have a senior-level Medicare representative listen in to gain an understanding of the issues and determine whether support on the Medicare side was feasible. Officials from a couple of states asked that CMS clarify the process for states to request Medicare participation, so they could understand what could and could not be done, and who makes those decisions. Even if Medicare cannot actively participate in the planning process, clarification would help the state set expectations with its stakeholders. Another state mentioned that an announcement from Medicare that "they're going to come in and align with what we're doing" would be helpful.
- **Provide background information to facilitate planning.** Stakeholders asked that CMS identify and share strategies and best practices that have been successful or might be implemented nationally. In particular, they asked CMS to provide states with summaries of evidence on the effects of different health care delivery system and payment models. Several stakeholders believed CMS could have (1) provided more guidance on what it saw as the best opportunities for states to lower health care costs, improve quality of care, and raise health status, and (2) been more explicit in framing the process around those goals.
- **Promote and encourage more peer-to-peer sharing mechanisms for the states under the SIM Initiative.** Several states requested that CMS set up a peer-to-peer sharing mechanism for the states under the SIM Initiative. A state official in one state, for example, is very interested in learning about how projects were administered in other states—how contractors were used is a particular interest. Related suggestions were to organize conference calls between key stakeholders in different

- states and provide a master listing of available technical assistance with target audiences and topics. Although CMS has provided several shared learning and information diffusion opportunities for SIM awardees (weekly webinars from national experts and federal agencies, group technical assistance, shared learning platform with posted resources), many of the SIM participants were not able to access these resources—some because they were too busy or could not attend—but others noted that they were not aware of the resources.
- **Identify neutral facilitators for the stakeholder engagement process.** Some states requested CMS’ help in identifying a “neutral” party to facilitate the stakeholder engagement process. States asked for CMS to identify resources or consultants who can facilitate this process.
 - **Provide better and more individualized communication with the state.** One state noted that efforts on this scale require a lot of pieces to be moved around, particularly on the legislative and policy side, and that state timelines do not always correspond to federal grant cycles. They requested better and more individualized communication with the states, so all parties are working together and with the same expectations.
 - **Be realistic about short-term ROI for SIM models.** States were concerned that the expected return on investment (ROI) may not occur within the 3-year Model Test period. They asked that CMS set more realistic expectations for ROI and allow longer demonstration periods, noting that it is difficult to achieve ROI in just a couple of years. One state official suggested that, instead of ROI, CMS use other measures to evaluate progress in the initial development period—such as infrastructure development, collaborations built, and milestones met.
 - **Award the Round 2 funds as quickly as possible.** The time and funding gap between the planning process and the Round 2 testing phase is problematic. Several states expressed concern that interest among stakeholders and momentum for Plan implementation would wane given the considerable time gap between the Model Design/Pre-Test phase and the Round 2 Test phase. The time gap also raises practical concerns related to retaining staff with knowledge and history of the Initiative.
 - **Consider weighting SIM funding in proportion to the state’s health budget.** The more populous states noted that their health care budgets were an order of magnitude larger than those of smaller states. Because a state’s size and complexity significantly influences the level of investments required for statewide transformation, the larger states requested that CMS take these factors into consideration when determining SIM Round 2 award amounts.
 - **Be clear about what kind of support CMS will be able to provide after the planning process.** Besides funding, states listed guidance on the types of models states may adopt, and assurances that key CMS agencies such as Medicare would agree to participate in implementation of the model elements that require these agencies’ participation.

- **Better coordinate the different initiatives of the Center for Medicare and Medication Innovation.** Multiple stakeholders commented on the overlap among various CMS demonstrations and initiatives focused on the same goals (i.e., better care, lower costs, improved health). Because it is becoming increasingly impossible to attribute an effect to any particular intervention, model, or strategy, they recommended that CMS use a more logical approach for releasing requests for proposals for grants. One state noted that the release of the Health Care Innovation Award Round 2 request for proposals interfered with state efforts to build a strong, statewide approach through SIM. The Health Care Innovation Awards encourage individual entities—often key stakeholders in the SIM effort—to go off and do their own thing rather than work with the state to develop a broader approach.

On one issue, the states had conflicting opinions and no clear, single recommendation emerged. This issue and the states' differing perspectives are summarized below.

- **The 6-month planning window was adequate for some states but not others.** Several stakeholders and SIM staff wished they had more time to engage stakeholders and develop and write the Plan. One SIM staff person suggested that a longer time period with interim deadlines would have been a better approach. Another noted that having only 6 months pushed the state to have biweekly, rather than monthly, meetings, which was positive for the process. A third state official was disappointed when CMS offered the 2-month no-cost extension. That official felt the Plan could be developed in 6 months and that the extension slowed momentum among the larger stakeholder groups. But another state official said the extension was necessary to have a collaborative process to design the Plan and write a detailed description. Officials in the same state said they would have planned the stakeholder engagement process and consensus building differently had they known they would have a longer planning period from the beginning. This would have allowed more time to get stakeholder and public feedback on the evolving plan and to keep momentum with internal and external stakeholders during the end phase of the design period, when no formal stakeholder activities had been planned.

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6. California

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California has a record of innovation and leadership in health care delivery, with one of the highest rates of penetration by managed care and surpassing most states on cost and quality benchmarks. The state also participates in a wide range of federal demonstration programs targeting specific groups, which directly support certain components of the State Health Innovation Plan (the Plan). To build on this foundation, Governor Jerry Brown convened a statewide task force, the Let's Get Healthy California (LGHC) task force, whose recommendations served as the focus and starting point for efforts to develop the Plan under the State Innovation Model (SIM) Model Design award. The CalSIM group, convened by the California Health and Human Services Agency (CHHS), involved a large and diverse group of major stakeholders and obtained input from regional and national authorities on health care delivery to develop the Plan. Public comments were solicited during both the planning phase and after the Plan's release.

The Plan has four major initiatives: (1) establish health homes for medically complex patients, (2) develop pilot accountable care communities (ACCs) that incorporate a wellness trust as part of their long-term funding model, (3) improve maternity care, and (4) promote the use of palliative care. Most of the proposed innovations would use voluntary, collaborative engagement. Major state payers participated in the Plan's development and are supportive of it, as are important private organizations such as Blue Shield of California, the California Endowment, and the Integrated Healthcare Association (IHA), among others. The IHA, in particular, would be the primary forum for working out the Plans' payment reform elements. Additional policy levers may include Medicare hospice waivers and facilitating state legislation (some of which has already become law).

The final Plan estimates that the first three initiatives would touch more a quarter of the state's population, producing estimated savings of \$1.4 to \$1.8 billion over 3 years. The health homes for the medically complex patients initiative alone is projected to account for 85 percent of the savings—as it would involve all payers and the most costly patients.

6.1 Context for Health Care Innovation

A wide range of factors were relevant to the development and shaping of the California Plan, including California's size and population diversity, strong political and stakeholder support, unique health care profile, and a large number of existing health care initiatives, especially the recent LGHC Task Force.

Population size and regional diversity. With a population of more than 38 million in 2012, California is the most populous state in the nation. It is also one of the most economically and socially diverse, with large disparities in health-related metrics, including cost (highest in the Los Angeles and San Francisco metropolitan areas), managed care penetration, health care utilization and outcomes, and number of individuals lacking insurance or from special populations (Lewin Group, 2013; SHADAC, 2012).

Health care profile of California. Profiles of health care in California reveal many bright spots and opportunities for improvement. A Centers for Disease Control and Prevention (CDC) 2012 review of eight major population indicators (including the percentages who smoke, are obese, and who exercise, and three diabetes indicators) found that California was above national averages in every category (CDC, 2012). California also exceeds national averages in adopting electronic health records (EHRs) and outperforms most states on Healthcare Effectiveness Data and Information Set measures and Consumer Assessment of Healthcare Providers and Systems surveys of patients. California is well below national averages on preventable hospitalizations (1,046 vs. 1,395 per 100,000 per year), Medicare readmissions (16.7 percent vs. 18 percent), emergency room visits (293 vs. 411 per 1,000 per year), percentage of low birthweight infants (6.8 percent vs. 8.1 percent), and a host of other measures. Importantly, California's annual spending per patient is substantially below national averages for both Medicare (\$8,975 vs. \$9,477) and Medicaid enrollees (\$3,527 vs. \$5,325) (SHADAC, 2012).

With respect to opportunities, a notable high-cost area is at the end of life: despite having a younger population than most states, California spends \$46,000 per decedent in the last 6 months of life, placing it in the 70th percentile nationally (Dartmouth Atlas, 2013). California also exceeds national averages on uninsured individuals (18.7 percent vs. 15.8 percent) and the fraction of patients reporting fair or poor health status (18.7 percent vs. 16.9 percent) (SHADAC, 2012). The LGHC report also emphasized overarching issues in California, noting that "The health care delivery system isfragmented, uncoordinated, and financially unsustainable" (LGHC Task Force, 2012).

Supportive environment. Interviewees cited California's history as providing positive political context for health care reform. Health care reform, spurred by efforts to reduce costs while improving quality, has involved both the public and private sectors. Additionally, interviewees remarked on the ongoing involvement in health care reform of a number of active foundations and academic medical centers: "There's a very active stakeholder and advocacy base, as well as folks in private industry who are very active in pulling people together to come up with these reforms. Our stakeholders are not shy."

Shift toward managed care. California, as noted, has one of the highest penetration rates for managed health care in the nation; 48 percent of individuals are in managed care compared to only 23 percent nationwide. Public plans include Medi-Cal, the state's Medicaid

program, in which over half the enrollees are covered by managed care. As of November 1, 2013, all counties offer managed care options to Medi-Cal enrollees, including children, seniors, and persons with disabilities. Approximately 25 percent of Medicare enrollees participate in managed care (Lewin Group, 2013).

Since the 1980s, California health purchasers and providers have been working to study and implement various approaches to health care reform, including participation in studies of value-based payment systems linked to managed care and integration of case management. For example, the California Public Employees' Retirement System (CalPERS) is currently partnering with another large purchaser coalition in the state, the Pacific Business Group on Health, to implement a high-intensity case management program (Davis and Long, 2013).

The LGHC Task Force and other existing health care initiatives. The LGHC Task Force was the largest single factor influencing development of the Plan. In 2012, the Governor signed an executive order to create the LGHC Task Force, with the charge to identify 10-year targets to “make California the healthiest state in the nation.” The task force comprised a wide range of public and private stakeholders. Together, they identified 39 indicators and 10-year targets in six key health care areas, although the task force did not discuss the process and levers through which those goals would be achieved. The SIM Model Design award became available just as the LGHC report was issued, allowing California to immediately transition to a process of defining how to reach the LGHC goals, building on the LGHC recommendations and the strong network of stakeholders who had come together. One interviewee noted, “... the Let's Get Healthy Task Force was a really great starting point and was a catalyst for the work we're doing. We would not have such a robust process had it not been for the involvement of those folks in Let's Get Healthy previously.”

Many private and public sector programs currently in place are increasing the capacity of providers to serve as patient-centered medical homes (PCMHs) and health homes. In the private sector, 32 primary care practices have National Committee on Quality Assurance certification as a PCMH, the California Primary Care Association is supporting its members' transition to health homes, and several public and private grants are funding initiatives to develop health homes across the state. The state is exploring supporting health homes through a Medicaid state plan amendment for Health Homes Planning Grant. Finally, 68 federally qualified health centers (FQHCs) are participating in CMS's FQHC Advanced Primary Care Practice Demonstration.

In the area of payment reform, pilot programs in California are testing a range of models, including “global payment, bundled payment, shared savings/shared risk within an accountable care organization infrastructure, medical home enhanced payments, reference pricing, tiered and limited networks, and P4P [pay for performance]” (Davis and Long, 2013).

Ongoing health IT initiatives include San Francisco’s Web-based eReferral program, which facilitates communication between primary care providers and specialists. A number of organizations, including the Department of Health Care Services (DHCS), are participating in an eHealth Initiative designed to promote health information exchange (HIE) capacity in the state. With regard to infrastructure to support data analysis, the California Maternal Data Center Initiative has plans to foster collection and reporting of information and performance metrics on maternity care services to participating hospitals. California does not currently have an All Payer Claims Database (APCD).

In addition to the initiatives already mentioned, the Plan details dozens of other initiatives already under way across the six LGHC target areas that could serve as a foundation for further innovation (State of California, 2013c, Appendix III, Table III-6). These initiatives, including collaborative activities and investments by private stakeholder groups, were particularly salient to the CalSIM planning effort, which used the existence of ongoing programs as a primary selection criterion for selecting the final initiatives and building blocks included in the Plan.

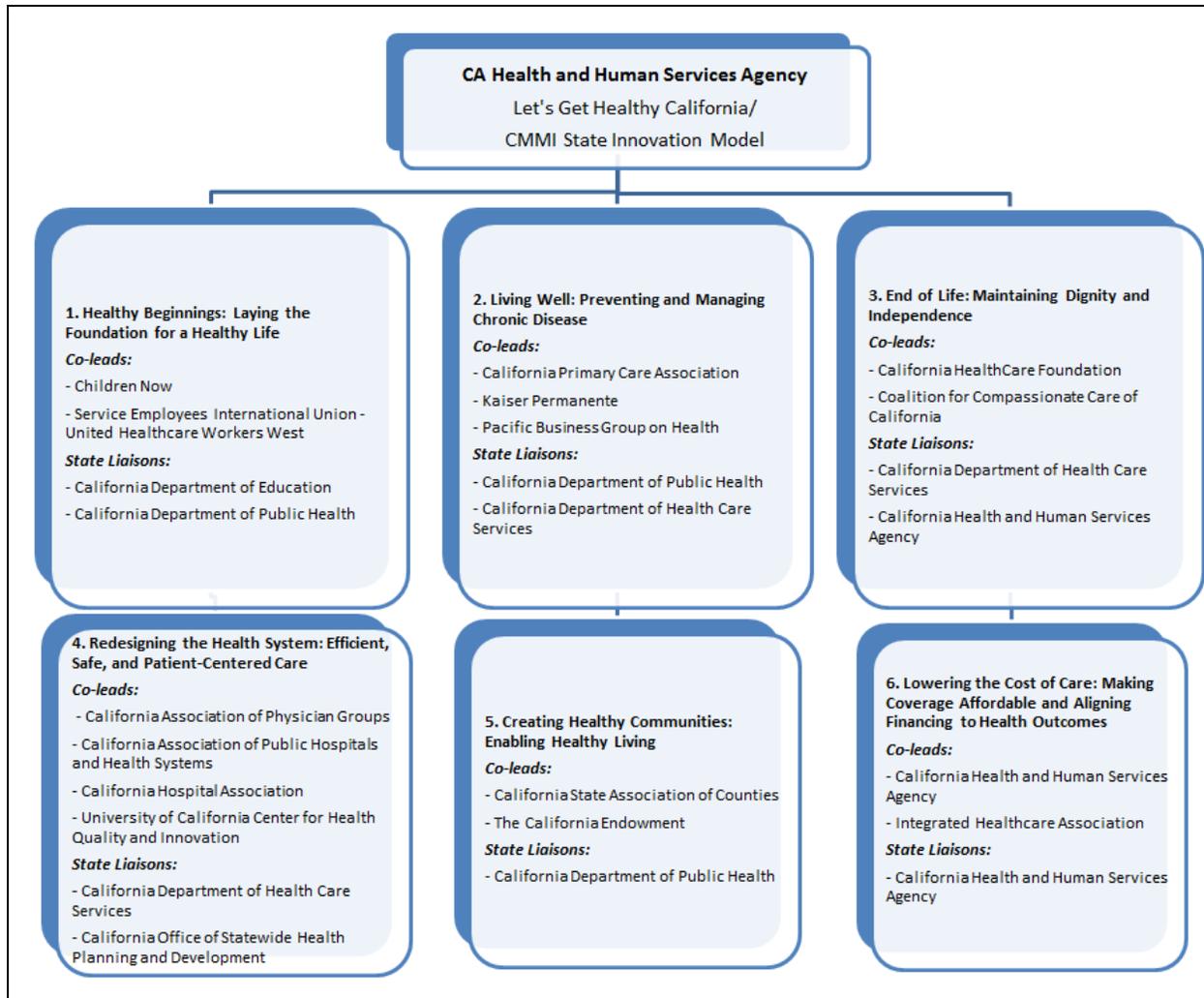
6.2 Planning Infrastructure and Process

Governance and management. Endorsed by the Governor, the California Health and Human Services (CHHS) Agency led the Plan development process. Under CHHS leadership, the project was directed by a four-member SIM planning committee and was supported by contracts with the University of California (UC) Davis Institute for Population Health Improvement for management and research support, with UC Berkeley for research, and with the Lewin Group for research and data analysis (State of California, 2013a). In addition to other documents, the Lewin Group produced a detailed market assessment in collaboration with UC Berkeley (Lewin Group, 2013).

Work groups. The CalSIM work group structure, shown in *Figure 6-1*, was based on the six foundational building blocks identified by the LGHC Task Force, with one SIM work group focusing on each: (1) Healthy Beginnings, (2) Living Well, (3) End of Life, (4) Redesigning the Health System, (5) Creating Healthy Communities, and (6) Lowering the Cost of Care. Groups 1–5 were primarily headed by individuals involved with private sector stakeholder organizations. For each work group, the state invited two to three such individuals to serve as official co-leads, who were then tasked with selecting and inviting five to 10 additional members from other stakeholder organizations or groups (State of California, 2013a). Work groups 1–5 included two representatives from state agencies who served as state liaisons. Work group 6 was distinct from the others in leadership, membership, charge, and operations. This group was co-led by the CHHS Secretary and consisted predominantly of state officials and key private sector advisors. Work group 6 was charged with financial impact analysis and making final decisions and

recommendations of the Plan elements. Several work groups created subgroups to explore specific areas or topics.

Figure 6-1. California SIM work group structure



Source: State of California, 2013a.

Each work group provided separate recommendations in three areas: payment reform, public policy, and private sector involvement. These suggestions (40 in all) were then forwarded by the work group co-leads to work group 6 for final consideration, facilitated by financial and feasibility analyses provided by the Lewin Group (State of California, 2013d). Necessarily, many recommendations were not selected for inclusion in the final Plan. Stakeholders said, for example, that plans to include children in the health homes were not included, neither were programs that would better align physician payments so as to encourage medical trainees to choose primary care as a career option.

Stakeholder engagement. With the possible exception of patients, who were not officially represented on any of the work groups, the CHHS leadership ensured that a broad spectrum of private and public sector stakeholders were represented in the Plan development process, including advocacy groups, foundations, health plans, payers, provider organizations, and academic medical centers. Each of the six work groups considered a particular niche within the health care landscape, and the co-leads and state liaisons selected represented organizations and agencies with leadership capabilities, expertise, and experience relevant to that work group’s charge (see [Figure 6-1](#)). Co-leads were personally invited by the CHHS Secretary or by the SIM Project Director. To the best of interviewees’ knowledge, all invited stakeholders accepted. Planning members participated enthusiastically and without compensation except for meeting-related travel. Given the size of California, work groups 1–5 met by conference call. The lack of face-to-face meetings did not seem to affect productivity, largely because many members were already acquainted through LGHC or other health planning projects.

The opportunity for public participation occurred through public announcements and calls for comments during the planning phase and after release of the draft Plan. Formal and informal comments were received in writing, via telephone calls, and from Web-based input.

Although the state convened and led the planning effort, one element of the planning was to leave the process of generating ideas and settling on recommendations to the private sector participants. As stakeholders confirmed, this was a “from the bottom up” process facilitated by the earlier LGHC initiative.

Outside financial support. The CalSIM planning effort benefited from supplemental financial support prior to receipt of the Model Design award to fund background research from several participants, including Blue Shield of California and The California Endowment (which also funded LGHC).

6.3 The California Plan

6.3.1 Models and Strategies

The Plan (State of California, 2013b), as noted, envisions four major initiatives and six foundational building blocks. [Appendix Table 6A-1](#) presents a summary of each model proposed, including the target population, relevant existing initiatives, enabling levers, and the parties involved in implementation.

6.3.2 Major Initiatives

Health homes for complex patients. California’s health homes initiative is intended to address the health care costs associated with medically complex patients by improving health status, increasing patient access to primary care, using value-based payment, and reducing

preventable hospitalizations. As elsewhere, medically complex patients consume a disproportionate share of health care costs in California. An independent analysis reported that just 7 percent of Medi-Cal patients account for 73 percent of the costs (California Healthcare Foundation, 2010). This initiative seeks to use team-based, coordinated primary care to improve outcomes and reduce cost. Distinguishing it from most health home programs, the California initiative will focus on the most complex patients, not on entire populations or practice panels, although the definition of “medically complex” has yet to be established.

This initiative will expand coordinated care in California beyond the existing public and private sector initiatives outlined above. State purchasers and select large employers, providers, and health plans will work to spread health homes for complex patients by: (1) working with CMS to define the required functionality needed for a health home for complex patients to satisfy market needs, certification requirements, and criteria from the Patient Protection and Affordable Care Act (ACA) Section 2703; (2) requiring health plans to develop innovative provider incentives to achieve the health home functionality specified; and (3) asking providers to demonstrate their use of frontline and allied professionals to facilitate cultural engagement with patients.

Accountable Care Communities. This initiative seeks to establish two to three pilot communities that establish coalitions of health care and non-health care entities. The ACC will address one of three chronic conditions that have demonstrated health disparities (asthma (especially in children), diabetes, or cardiovascular disease) through common goal-setting and implementation of community-based, prevention-oriented interventions that will yield savings within 3 years. The model for the ACC comes from a program established in Akron, Ohio, and adds a Wellness Trust funding mechanism in each ACC, patterned after those in Massachusetts and North Carolina, to capture resulting savings and attract other revenue sources to reinvest into the community. A central feature of these models is use of community health workers as bridges among the health care system, community organizations, social service providers, and individuals who are the focus of the initiative.

Maternity care. This initiative is designed to reduce early elective delivery rates by 50 percent to less than 3 percent by the end of 2017, reduce Cesarean section rates overall by 10 percent by the end of 2017, and increase the rate of vaginal births after Cesarean delivery from 9 percent to 11 percent by the end of 2017. It envisions four components: (1) universal hospital enrollment in the California Maternal Quality Care Collaborative (CMQCC), (2) developing a plan to incentivize hospitals to reduce unnecessary elective Cesarean section deliveries, (3) working toward use of a blended payment rate for deliveries (eliminating higher reimbursements for elective Cesarean sections), and (4) establishing a team to monitor performance targets and troubleshoot outlier facilities, identified through the CMQCC.

The Plan builds on recommendations from the LGHC report, and work conducted in other states, as well as several existing California-based programs that target maternal health care and costs. As an example, Dignity Health reduced avoidable elective Cesarean sections (State of California, 2013b).

Palliative care. This initiative seeks to improve palliative care practices in accord with patient preferences, by educating patients and providers and reducing structural barriers to palliative care delivery. Specifically, California aims to affect indicators such as the percentage of California hospitals providing inpatient palliative care, hospice enrollment rates, the occurrence of advanced care planning, and the rate of preventable hospitalizations. Palliative care programs are in place in 63 percent of public hospitals in California, but only in 32 percent of the state's private hospitals. Moreover, as noted, the Medicare costs per decedent in California are among the highest in the nation (Dartmouth Atlas, 2013). Surveys show a large disconnect between patient wishes and care provided: 70 percent said they would prefer to die at home, but 42 percent of deaths occur in the hospital. The palliative care initiative seeks to address the misalignment between patient preferences and care delivery, by including optimal palliative care services within the new health homes for complex patients, and by adopting new benefit and payment reforms relating to end-of-life care. To facilitate implementation of this initiative, the state will pursue a Medicare hospice waiver to allow curative and palliative care to be provided simultaneously through Medicare and extend the hospice benefit to within 12 months of anticipated death.

6.3.3 Building Blocks

The Plan identifies key infrastructure components needed to promote and sustain long-term transformation envisioned in the initiatives described above. These foundational elements are included as the Plan's six building blocks. They are vital to the Plan, but would also support many other aspects of health care reform in the state beyond the SIM Initiative.

Workforce development. This building block is intended to address California's present and anticipated shortage of primary care medical and behavioral health professionals—a problem it anticipates will be exacerbated by the potential addition of up to 5.9 million newly insured persons beginning in 2014 (State of California, 2013b). The goals of this building block are to bolster training opportunities for health workforce personnel involved in the four initiatives described above and to increase the use of lower cost, frontline health workers. SIM funds would be used primarily to enhance ongoing training efforts and increase the efficiency of the existing workforce.

Health IT. California envisions this building block as a means of addressing gaps in its health IT and HIE infrastructure. The state and private stakeholders are currently conducting numerous initiatives to increase EHR and HIE uptake in California. This building block seeks to

support both these existing initiatives and those in the Plan, by providing health IT support to entities involved in health homes for complex patients and commissioning third-party business-case analyses and additional research to examine questions relating to return on investment (ROI).

Cost and quality reporting system. The primary objective of this building block is creation of a cost and quality reporting system database. Working with the California Healthcare Performance Information System—a nonprofit, public benefit corporation that has already made significant progress in aggregating claims and eligibility data from California’s three largest health plans—as well as the Integrated Healthcare Association, the state will explore the benefits, drawbacks, and potential for public-private partnerships regarding an APCD, and develop a proof-of-concept project to demonstrate the value of such a system.

Public reporting. The goal of this building block is to facilitate monitoring of LGHC indicators and give stakeholders and the public a means of using data to improve quality and outcomes. The state will establish a Web site that allows the public to access information on LGHC and Plan performance metrics, health disparities in the state, and ongoing initiatives.

Payment reform innovation incubator. This building block facilitates collaborative work to develop and spread payment reforms by expanding the membership and role of the Integrated Healthcare Association (IHA). *Appendix Table 6A-1* describes the steps IHA will take to promote payer, provider, and purchaser collaboration on systemwide payment reform activities.

Enabling authorities. This building block refers to the legislative and regulatory activity that may be needed to support the four main initiatives. As described above, this legislative and regulatory activity may include the following: (1) taking advantage of Section 2703 of the ACA to implement health homes for complex patients; (2) pursuing a Medicare hospice waiver in support of the palliative care initiative and considering participation in a concurrent care demonstration program; (3) reviewing the ACA’s final rule on the scope of nonphysician providers that can be reimbursed by Medicaid for preventive services; and (4) exploring legislation related to APCD implementation, such as a requirement that all payers in the state participate in APCD.

6.3.4 Policy Levers

Existing and proposed policy levers for Plan implementation are listed in *Appendix Table 6A-1*. The Plan envisions its six embedded building blocks as the main enablers for the four health care initiatives. The Plan says that most of the proposed innovations can be enacted without new authorities—that voluntary, collaborative engagement will be a major approach used to achieve payment and programmatic reform. Major state payers, including CalPERS,

Covered CA, and DHCS-MediCal, were involved in the development of the Plan and support its implementation. Deriving from a process led by CHHS and strongly endorsed by the Governor, enthusiastic cooperation is anticipated; as one stakeholder expressed: “I think it’s hard to think of a stronger policy lever than that.”

The Plan also says, however, that a range of additional levers might be needed. For example, regulatory or legislative actions may be necessary to mandate filing to a cost and quality reporting system. Recent state legislation is also supportive: State Assembly Bill 361 enables DHCS to create a health home program, continuing efforts started under a prior federal planning grant.

California participates in a wide range of federal demonstration programs targeting specific populations, such as patients with HIV/AIDS, mental retardation, or behavioral disability (State of California, 2012). Many of these are directly supportive of the SIM Model Design initiatives.

California benefits from a number of private organizations that seek to promote health care quality, equity, and value in the state. These organizations already support programs relevant to the Plan’s success. For example:

- The California Endowment has committed \$52 million over 3 years to support efforts by the Office of Statewide Health Planning and Development to enhance the California health care workforce, especially in underserved communities. The Endowment also funded the LGHC Task Force and its own research relevant to CalSIM, notably with respect to health homes.
- Blue Shield of California provided funding for research related to the workforce, notably issues related to community health workers.
- The Pacific Business Group on Health operates a warehouse of data on Medicare and private claims for three large insurers (although no Medi-Cal data).
- The California HealthCare Foundation funds a large demonstration project around end-of-life issues, the Institute for Palliative Care at CSU, and the Maternal Data Center.
- The Integrated Healthcare Association sponsors cross-stakeholder initiatives to improve health care quality, accountability, and affordability in California and a wide range of relevant transformative initiatives. IHA is targeted to be the primary forum for working out details of the payment reform elements of the Plan and to develop any needed performance metrics not already available.
- The Berkeley Forum convened cross-stakeholder discussions on payment reform.

Provisions of the ACA also support various aspects of the Plan. Section 2703 provides enabling mechanisms for new health homes, Section 3140 authorizes palliative care demonstrations, and other provisions support workforce reform by expanding the reimbursable services that can be provided by nonphysician providers.

Finally, the Plan may require federal waivers. Medicare hospice waivers may be required, for example, to allow patients receiving hospice care to also receive curative treatments and other Medicare-reimbursable services.

6.3.5 Intended Impact of the Plan

Estimates provided in the final Plan project that three of the four major initiatives (palliative care, maternity care, and health homes) would touch more than 8 million individuals in the state, roughly one quarter of the population. The ACC initiative would involve the smallest patient cohort, given the limited scope anticipated. Estimated savings to California's health care marketplace from the Plan initiatives total \$1.4 to \$1.8 billion over 3 years; approximately 85 percent of this amount is to be derived from the health homes for complex patients initiative, which involves all payers and the most costly patients.

The initiatives clearly address areas of health care disparity, which are evident in evaluating maternal health, the care of patients with chronic illness, and patients approaching the end of life.

6.3.6 Proposed Next Steps

CHHS is conducting a series of rapid-cycle evaluations that would facilitate rapid implementation of the proposed initiatives if the Plan is funded through a Round 2 Model Test Award. Meetings with foundations are also being held to consider private strategies that could complement the Plan.

Plans for administration of the testing phase have not been announced, nor have there been any estimates of how testing funds would be allocated among the competing initiatives and building block proposals.

6.4 Discussion

The most significant aspect of the CalSIM planning process was its intimate relationship to the earlier LGHC Task Force report, issued in December 2012 (LGHC Task Force, 2012). The ability to transition directly from LGHC to CalSIM planning provided a number of benefits:

- The CalSIM planning structure was based on the six goals developed by LGHC, and many of the same committee members from LGHC continued their work for CalSIM.

- Momentum was already established and was sustained; CalSIM hit the ground running.
- Many of the measures to be considered had already been proposed, researched, and vetted. The CalSIM planners were able to begin with identified goals and to build on existing relationships between highly motivated stakeholder groups.

The relationship unquestionably facilitated timely completion of the Plan, and also its ability to include so many different elements.

The relationship may have also created some constraints, according to stakeholders—for example, that starting with a full slate of ideas from LGHC may have precluded consideration of novel suggestions. However, interviewees noted that the 3-year ROI requirement in the SIM application necessitated leveraging existing initiatives, because development of truly novel approaches would require longer than 3 years. A second concern stakeholders expressed is that charging each work group to make recommendations produced a large final set.

All elements of the Plan have laudable goals and provide an excellent likelihood of improving health care quality and value in California, according to stakeholders. However, stakeholders also had some concerns. One that emerges from review of the Plan is whether it would reach 80 percent of the state population. Even if this were not achieved, the number of individuals ultimately affected would likely greatly exceed the number affected by SIM programs in smaller states, according to interviewees. A second concern noted by interviewees is that the initiatives promoting health homes and ACCs in the Plan seem constrained and limited. Details about these two initiatives in the Plan are scant compared to those about the maternity care and palliative care initiatives, which are described concretely and in depth. Work group members noted that the latter two initiatives are focused on narrow, well-described populations, and built on existing well-defined initiatives, whereas “complex patients” and ACCs are less concretely defined and would require further development during the SIM testing phase, if the grant is awarded.

Participants in the planning viewed the process as important in bringing the state more into the discussion of health care transformation: “This was the first time I’ve seen the state take a tangible leadership role; traditionally California has been very inactive,” one stakeholder reported. Another remarked that the true novelty of the approach was the close degree of collaboration among a nearly complete spectrum of stakeholders—for example, private and public payers, and providers of primary, acute, and chronic care. This kind of close collaboration during the development phase is seen as critical to the feasibility and success of models that involve collaboration during implementation, such as ACCs and health homes for complex patients. However, stakeholders commented that whether these collaborations persist into the

implementation phase remains to be seen. One stakeholder commented that there remains a substantial element of self-interest on the part of at least some participants.

6.4.1 Critical Factors Shaping the Plan

The three most critical factors shaping the Plan were the framework and goals established by the LGHC report, the expectations of the SIM Model Design awards (specifically the requirement for projects to reach 80 percent of the population, and that models and strategies proposed in the Plan would have an ROI within 3 years), and the existing programs in the state. The work groups were organized according to LGHC goals and included many of the same stakeholder representatives. Each work group was tasked with proposing recommendations on how to achieve these goals (State of California, 2013c). Based on a formal analysis by the Lewin Group, initiatives were also prioritized and selected to the extent they reached the most patients, targeted special populations, promised the greatest ROI within 3 years, and promoted delivery and payment reforms (State of California, 2013d). To provide ROI within 3 years, work group members largely focused their attention on existing reform initiatives. A key factor, especially for the maternity care and palliative care initiatives, was the ability to build on existing programs.

Another key factor in development of the plan was the process used to create it. Stakeholders were uniformly complimentary of the process used to develop the Plan. Management of the process was described as exceptional, and the ability to generate a comprehensive plan in a period of just a few months was considered the more remarkable for the large number of stakeholders and large number of initiatives considered. Public transparency, according to all stakeholders, was planned and achieved. Other aspects of the planning process highlighted as important include the following:

- early and ongoing endorsement and involvement by the Governor and CHHS Secretary;
- excellent project management—provision by state leadership of clear guidance to the various work groups, setting and monitoring appropriate timelines, and maintaining constant communication with each group;
- building on earlier work—the ability to move directly from the LGHC project to CalSIM planning was a coincidence, but highly fortuitous;
- subcontracting resource-intensive parts of the planning (e.g., financial estimates) to the Lewin Group, UC Davis, and UC Berkeley;
- dividing up the work among the different work groups and subgroups;

- drafting planning committee members who were committed, energetic, and knowledgeable;
- buy-in from major purchasers; and
- strong collaboration among diverse stakeholders, including some who had not previously had the opportunity to work together.

Contributing to the planning effort was the expertise of the people involved. As one stakeholder summarized it: “This is really as blue ribbon a collection of people as you’ll find.” This started at the top, with leadership provided by the CHHS Secretary and the SIM Project Director, a highly respected and seasoned health care leader in the state. The quality of staff continued into the work groups; many members head the largest and most important foundations, coalitions, associations, and organizations involved in California health care.

6.4.2 Lessons Learned

The primary lessons learned from the California planning experience include the following:

- **Stakeholders can be energized by giving them both responsibility and authority.** California energized stakeholders by giving them both responsibility and authority for developing the Plan. Leadership and empowerment from the highest levels of state government was also seen as critical. Interviewees strongly recommended that other states model their planning process after that of CalSIM where possible, and referenced specifically the factors described above, which they viewed as contributing to the success of CalSIM planning.
- **Strive to incorporate better representation from patients, populations of interest, and consumers.** Work group members commended Plan leadership for convening a diverse group of stakeholders; a few noted, however, that there could have been more members whose official function was to represent the patient voice. Another commented that it might have been appropriate to include representatives for senior citizens or diverse ethnic groups, given the Plan’s goal to reach 80 percent of the population.
- **Include CMS representatives in the various discussions as an important payer.** Several individuals recommended that at least one CMS representative be included during the planning process, given CMS’ special role as a dominant payer.
- **Develop in advance a strategy for dispute resolution during work group decision-making.** Although most work groups made decisions via consensus, several found this to be a challenging process given the short timeframe and very disparate stakeholder views. Some felt that creation of a process for dispute resolution in

advance would have allowed the decision-making process to proceed fairly in the absence of complete unanimity.

6.4.3 Potential for Implementation

Stakeholders were unanimous in their belief that the proposed initiatives and building blocks were each feasible and could be implemented successfully with appropriate funding. Stakeholders described the Plan as ambitious, while acknowledging that many of the initiatives were more incremental than groundbreaking, and chosen to build off existing programs. Stakeholders expressed these perceptions about the individual initiatives:

- The Maternity Care Initiative was perceived as the easiest to implement, given the foundational work sponsored by the California Healthcare Foundation (Maternal Care Data Center) and others. Moreover, California already has the fifth best rates of avoidable preterm deliveries.
- The Palliative Care Initiative was perceived as the most important, with the largest potential for cost savings.
- ACCs were perceived as the most important initiative for shifting health care toward a preventive approach via financial incentivizing. Some stakeholders perceived them as important but not innovative, noting that several areas in California already had ongoing community-wide projects. Others believed ACCs to be one of the more innovative initiatives proposed.
- Health Homes for Complex Patients was perceived by some interviewees as the initiative most in need of further specification, even while acknowledging that model programs may exist: What is a complex patient? What services would a health home provide, and how?

6.4.4 Applicability to Other States

Each of the four major initiatives proposed in the California Plan could be adopted by other states; indeed, several elements of the Plan (for example, the ACCs) are patterned after successful programs elsewhere. California has a unique head start on the Maternity Care and Palliative Care initiatives, given the many groups already engaged in these areas and the projects already under way.

6.4.5 Limitations of This Evaluation

This case study is based on a review of background documents, the final Plan, and interviews with stakeholders. Because we conducted stakeholder interviews before the state submitted its final Plan, the stakeholder comments reported here may not accurately reflect opinions of the final Plan.

6.5 References

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Appendix Table 6A-1. Models and strategies proposed in California Health Care Innovation Plan

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|--|--|--|---|--|
| Health homes for complex patients | <p>32 NCQA-accredited patient-centered medical homes already in existence in CA</p> <p>PBGH’s Intensive Outpatient Care Program targeting Medicare patients in 20 physician medical groups</p> <p>CA Primary Care Association support of patient-centered health home implementation among member clinics</p> <p>Health homes developed through DSRIP</p> <p>Bridge to Reform Section 1115 Medicaid waiver—expands access to county-based Low Income Health</p> <p>Programs with requirement that new enrollees are enrolled in a medical home</p> | <p>Persons with more than one chronic condition, dually eligible persons, and other complex patients</p> | <p>Proposed state executive branch action</p> <p>*Use state health care purchasing power to require health plans to develop innovative, non-fee-for-service incentives for providers</p> <p>Apply for Medicaid state plan amendment (DHCS)</p> <p>*Apply for and win Round 2 Model Test award to fund training to providers and facilitate voluntary actions</p> <p>Proposed state facilitated system change</p> <p>* Jointly define required functionality needed for health home for complex patients (proposed action of action of state purchasers and select large employers, providers, and health plans)</p> <p>*Develop innovative, non-fee-for-service incentives for providers (proposed action of select large employers)</p> <p>*Ask providers to demonstrate incorporation of frontline and allied health professionals into their teams (proposed action of state purchasers and select large employers and health plans)</p> | <p>DHCS, state purchasers; select large employers, providers, and health plans</p> |

(continued)

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Appendix Table 6A-1. Models and strategies proposed in California Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|---|---|---|--|---|
| | Cal MediConnect— initiative to foster greater care coordination for dually eligible individuals in eight counties Assembly Bill 361 (signed into law October 2013) authorizes the DHCS to establish a health homes program | | | |
| Accountable care communities Create Wellness Trusts and identify sustainable financing mechanisms Develop infrastructure and implement programs to address agreed-upon priority conditions Use CHWs or other frontline workers as bridges between the health care system, community organizations, social service providers, and individuals who are the intervention’s focus | City- and county-level community-wide initiatives (e.g., “Live Well, San Diego!” and the Beach Cities Health District) Integration of CHWs through public health department initiatives in 12 counties funded by Community Transformation Grants | Persons with or at risk for asthma, diabetes, or cardiovascular disease | Proposed state executive branch action Select communities to pilot ACCs (in process) *Apply for and win Round 2 Model Test award to provide initial funding | State; health systems, community organizations, social service providers, in selected pilot communities |

(continued)

Appendix Table 6A-1. Models and strategies proposed in California Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|----------------------------------|--|-----------------------------|---|---|
| Maternity care initiative | <p>Partnership for Patients hospitals that work with six Hospital Engagement Networks to identify and spread best practices for early elective delivery reduction</p> <p>California Maternal Quality Care Collaborative initiative to improve maternal and newborn health through birth-related data reporting and hospital system quality improvement projects</p> <p>PBGH 2014 pilot program to develop a blended facility payment for maternity care within four hospitals and medical groups</p> <p>Integrated Healthcare Association Pay-for-Performance Program—integration of maternity metrics in 2014</p> | Pregnant women and newborns | <p>Proposed state executive branch action</p> <p>* Use state health care purchasing power to: (1) require hospitals from which maternity care is purchased to report data to the California Maternal Quality Care Collaborative, and (2) implement value-based purchasing program that links substantial portion of hospital payments for maternity care to quality measures (in process)</p> <p>Develop a process to identify and oversee an annual review of outlier hospitals</p> <p>* Apply for and win Round 2 Model Test award to fund blended payment rates for Medi-Cal and other activities described above</p> <p>Proposed state facilitated system change</p> <p>Select large employers and health plans would: (1) require hospitals from which maternity care is purchased to report data to the CA Maternal Quality Care Collaborative and (2) implement value-based purchasing program that links substantial portion of hospital payments for maternity care to quality measures (in process)</p> | California Maternal Quality Care Collaborative, state purchasers, select large employers and health plans, state team |

(continued)

Appendix Table 6A-1. Models and strategies proposed in California Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|-----------------------------------|--|---|---|--|
| Palliative care initiative | <p>Coalition for Compassionate Care of California engagement of providers and patients in advanced care planning</p> <p>Palliative Care Action Community—initiative convened by the California HealthCare Foundation to advance the availability of community-based palliative care in the state</p> <p>California State University of San Marcos Institute for Palliative Care— offers replicable education/ training programs for health professionals and community members</p> <p>Health plan hospital systems pilots to deliver new models of care for people near end of life, (e.g., Sharp HealthCare <i>Transitions</i> “pre-hospice” program)</p> | Persons near the end of life, dually eligible persons | <p>Proposed state executive branch action</p> <p>*Review and adopt innovative benefit design and payment mechanisms related to palliative care</p> <p>Support training of current workforce regarding palliative care services</p> <p>Require health homes for complex patients to incorporate palliative care services</p> <p>*Pursue a Medicare waiver regarding palliative care services for hospice patients and align time window for hospice with current California law</p> <p>Proposed state facilitated system change</p> <p>*Incorporate palliative care services into Health Homes for Complex Patients Initiative</p> | state team, California HealthCare Foundation, the Integrated Healthcare Association, organizations participating in Health Homes for Complex Patients Initiative |

(continued)

Appendix Table 6A-1. Models and strategies proposed in California Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|--|--|---|--|--|
| Workforce development | Current OSHPD workforce investments | Populations served by Health Homes for Complex Patients, Palliative Care, and ACC Initiatives | <p>Proposed state executive branch action OSHPD will use \$52 million grant from The California Endowment to expand supply and capacity (through training) of workforce in underserved communities</p> <p>Identify opportunities to support workforce training to meet initiative objectives/needs (in process)</p> <p>Apply for and win a Round 2 Model Test award to fund (a) training programs, and (b) a multi-stakeholder process to propose a pathway to sustaining the CHW workforce (e.g., through financing, potential certification)</p> <p>Proposed state facilitated system change Use payment models for Health Homes for Complex Patients, Palliative Care, and ACCs to create demand for integrated frontline workers</p> | Entities involved in Health Homes for Complex Patients, Palliative Care, and ACC initiatives; OSHPD; state |
| <p>Health IT Provide TA to high-need entities and geographies developing health homes for complex patients</p> <p>Develop and promote third-party business case analyses of how technologies can produce savings</p> | <p>CHHS agency plans to connect state government with HIE activities in the state through three use cases</p> <p>ONC Health IT Trailblazer initiative—produced catalogue of programs, infrastructure, and metrics related to data measurement and reporting, QI, and payment reforms</p> | N/A | <p>Proposed state executive branch action Commission research on options for ensuring that data comparable to fee-for-service data can continue to be collected to inform cost and quality-of-care improvement efforts on a statewide basis</p> <p>*Apply for and win a Round 2 Model Test award</p> | State; entities involved in health homes for complex patients initiative |

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Appendix Table 6A-1. Models and strategies proposed in California Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|---|---|-----------------------|---|--|
| Cost and quality reporting system Explore development of a cost and quality reporting system through potential public-private partnerships or other mechanism, and develop a proof of concept project to demonstrate reporting system value | Integrated Healthcare Association and California Office of Health Information Integrity Partnership to demonstrate health plan use case for HIE IHA inclusion of meaningful use metrics in pay-for-performance program California Department of Public Health public health reporting gateway | N/A | Potential state legislative action Consider legislative options, such as legislation to establish a state cost and quality reporting system | State; CHPI |

(continued)

Appendix Table 6A-1. Models and strategies proposed in California Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|---|--|------------------------------|--|---|
| Public reporting Web site that will (a) report on LGHC goal areas and indicators, (b) identify “hot spots” of greater health disparities, and (c) spotlight promising initiatives | N/A | N/A | Proposed executive branch action OPA or an equivalent state department to develop Web site *Apply for and win Round 2 Model Test award to enhance Web site | CA OPA |
| Payment reform innovation incubator Expand IHA to include additional stakeholders Identify methodologies to measure goal of reducing fee-for-service payments and increasing performance- and value-based payments Facilitate development of an agreed-upon approach to measure total cost of care for non-managed care organizations Support initiative-specific activities | IHA work to support payment reform development, testing, and reporting | N/A | Proposed state executive branch action *Apply for and win Round 2 Model Test award to fund IHA activities Proposed state facilitated system change IHA will pursue activities as outlined in Plan | IHA and other stakeholders to be determined |

(continued)

Appendix Table 6A-1. Models and strategies proposed in California Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|------------------------|---|--|---|---|
| Enabling authorities | N/A | Populations affected by Health Homes for Complex Patients and Palliative Care initiatives and Workforce and APCD Building Blocks | <p>Proposed executive branch action</p> <p>*Health Homes for Complex Patients: Take advantage of Section 2703 of the ACA</p> <p>*Palliative Care: Pursue a Medicare hospice waiver that allows Medicare enrollees to obtain palliative and curative care concurrently Potentially pursue a demonstration program similar to the A6-authorized “Medicare Hospice Concurrent Care Demonstration Program”</p> <p>Workforce: Review final rule for Medicaid essential health benefits required under the ACA that expanded the scope of nonphysician providers who can be reimbursed by Medicaid for preventive services (in process)</p> <p>*APCD: If a voluntary approach fails, pursue legislative or regulatory activity related to the development of an APCD</p> | Participating stakeholders; state legislature; CHHS |

¹Policy levers include Medicaid waivers; federal grants (including Round 2 SIM award); state laws; state regulations; state investments (e.g., in public health programming); foundation grants; employer-led coalitions to drive change among providers, purchasers, or plans; state government-led coalitions, task forces, or commissions to drive voluntary change among providers, purchasers, or plans; state purchasing contracts; and state-level (Governor-initiated) executive policy directives.

Abbreviations: ACA = Patient Protection and Affordable Care Act, ACC = Accountable Care Community, APCD = all-payer claims database, CHHS = California Health and Human Services Agency, CHPI = California Healthcare Performance Information System, CHW = Community Health Worker, DHCS = Department of Health Care Services, DSRIP = Delivery System Reform Incentive Payments, HIE = health information exchange, IHA = Integrated Healthcare Association, LGHC = Let’s Get Healthy California, NCQA = National Committee on Quality Assurance, ONC = Office of the National Coordinator, OPA = Office of Patient Advocate, OSHPD = Office of Statewide Health Planning and Development, PBGH = Pacific Business Group on Health, QI = quality improvement, TA = technical assistance.

7. Colorado

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Colorado is one of three states awarded a “Pre-test” State Innovation Model (SIM) award. Development of the state’s Health Care Innovation Plan (the Plan) was led by the Department of Health Care Planning and Finance (HCPF), working closely with three partners: the University of Colorado Medical School’s Department of Family Medicine (DFM), the Colorado Health Institute (CHI), and the Center for Improving Value in Health Care (CIVHC). The state’s Plan builds directly on its original SIM Model Test proposal to the Centers for Medicare & Medicaid Services (CMS), with the overarching goal to ensure that 80 percent of all Coloradans have access to coordinated systems of care that provide integrated behavioral health care in primary care settings. The proposed strategies in the Plan all support the goal of care integration and include development of accountable care organization (ACO)-like care systems, statewide expansion of integrated patient-centered medical home (PCMH) models, implementation of a payment reform glide path that transitions providers from a predominantly fee-for-service (FFS) model to a risk-adjusted prospective per member per month (PMPM) payment with elements of shared savings, and development of health information technology (health IT) and data infrastructure to support this transformation. The Plan also includes a range of strategies aimed at linking clinical care to the public health system and other community resources and developing workforce capacity to provide integrated care. The state will begin this process by building on existing major initiatives, such as the federally funded Comprehensive Primary Care Initiative (CPCI or CPC Initiative) and Medicaid’s Accountable Care Collaborative (ACC), which the state hopes will serve as a model for other payers. Although it will apply for a Round 2 Model Test award, Colorado will likely seek additional funding support from other grant-making bodies, and may pursue elements of the Plan regardless of SIM funding.

7.1 Context for Health Care Innovation Plan

The Plan reflects the influence of many contextual factors. The most important include: (1) commitment among state officials and key stakeholders to the aims and goals outlined under the original SIM Model Test award proposal; (2) Medicaid’s existing regional ACO model, which launched in 2011; (3) ongoing Medicaid payment reform efforts, which include an upcoming global payment pilot; (4) existing PCMH initiatives such as the multi-payer CPCI; and (5) the state’s health IT and data infrastructure.

Colorado’s original SIM Model Test award proposal focused on integrating behavioral health into the primary care setting, which the state has maintained as the primary goal shaping the Plan. This focus on care integration builds on a number of previous efforts by both the state

and other key stakeholders active in setting the state's health policy agenda. For example, the Governor's State of Health Report identifies "improving health system integration" as one of four key focus areas for reform (Office of the Governor, April 2013), and the state is host to several integrated care pilots. Care integration is also a major funding target for the Colorado Health Foundation (CHF), a leading grantmaker in the state. CHF's funded projects include Advancing Care Together, a 4-year demonstration project aimed at testing integrated care models (University of Colorado, 2014), and the Promoting Integrated Care Sustainability initiative, which convened stakeholders from across the state to identify barriers to integration and propose policy solutions (Colorado Health Foundation, 2012). In 2011, the state legislature passed HB 11-1242, which directed HCPF to "report on state and federal laws affecting the integrated delivery of physical and behavioral health care, as well as barriers and incentives to delivering integrated care" (HCPF, 2012). Several of the report's findings are reflected in the Plan, particularly with regard to data-sharing issues, workforce training needs, and funding streams.

The focus on care integration also reflects broader efforts to reform the state Medicaid program. In 2008, Colorado enacted a major reform known as the ACC Program (Rodin and Silow-Carroll, 2013). The program, which began enrolling beneficiaries in 2011, is a regional ACO-like model. The state manages seven regional networks known as Regional Care Collaborative Organizations (RCCOs), which in turn manage networks of primary care providers. The RCCOs provide care management, coordination, and administrative support to their affiliated providers, which are expected to serve as medical homes for their Medicaid patients. This model uses an FFS plus a PMPM payment paid to both the RCCO and the medical home, with incentivized payment and eventually a shared savings component. By September 2013, roughly 55 percent of the state's Medicaid beneficiaries were enrolled in an RCCO (personal communication with state official). Ultimately, the state hopes to integrate the full range of services within the ACC program, including long-term care (LTC) (Rodin and Silow-Carroll, 2013).

In June 2012, the state also enacted reforms to its Medicaid payment system. At present, the state reimburses physical health services on a primarily FFS basis, while behavioral health services are carved out and reimbursed on a capitated basis. These services are managed by five regional behavioral health organizations (BHOs). Under HB 12-1281, HCPF was authorized to pilot alternative payment models within the ACC program. All seven RCCOs submitted proposals, of which one—submitted by Rocky Mountain Health Plan (RMHP)—was selected in July 2013. Beginning in July 2014, RMHP will receive a full-risk global payment for the entire population below 250 percent of the federal poverty level, without regard to coverage type (HCPF, July 2013). Though the global payment still does not include behavioral health services, because of the state's behavioral health carve-out 1915b CMS waiver program, the pilot does

include efforts to integrate and coordinate behavioral health and physical health services between the two programs.

Colorado also has several PCMH initiatives under way, the most noteworthy of which is the federally sponsored CPCI. This demonstration includes 74 practices and is jointly funded by Medicare, Medicaid, and eight commercial insurers (State of Colorado, December 2013). Colorado has a highly competitive commercial insurance market, and some stakeholders saw the CPCI as an important starting point for implementing payment reform across public and private insurers in the state, because these insurers had already demonstrated willingness to collaborate on this issue. Several noted that special efforts were made to align the Plan with the CPCI.

Colorado's existing health IT and data analytics infrastructures also play a key role in the Plan. The state has an all-payer claims database (APCD) that was established in 2010 and is administered by CIVHC. The APCD currently provides aggregated historic claims data from Medicaid and the 12 largest commercial payers in the state, dating back to 2009 (CIVHC, 2014a). The state also has two health information exchanges (HIEs): the Colorado Regional Health Information Organization (CORHIO), which also serves as the Regional Extension Center; and Quality Health Network (QHN), a member of the Colorado Beacon Consortium (State of Colorado, December 2013).

Other existing initiatives relevant to development of the Plan include: (1) the Health Extension System (HES) currently under development, which the state hopes to expand statewide under the Plan; (2) the Statewide Data and Analytics Contractor, which analyzes performance data for the ACC Program; (3) the Federation of Health Information Technology Organizations, which represents health IT organizations in the state and serves as a forum for aligning their efforts; and (4) the Colorado TeleHealth Network, which connects rural and urban providers for telehealth consults.

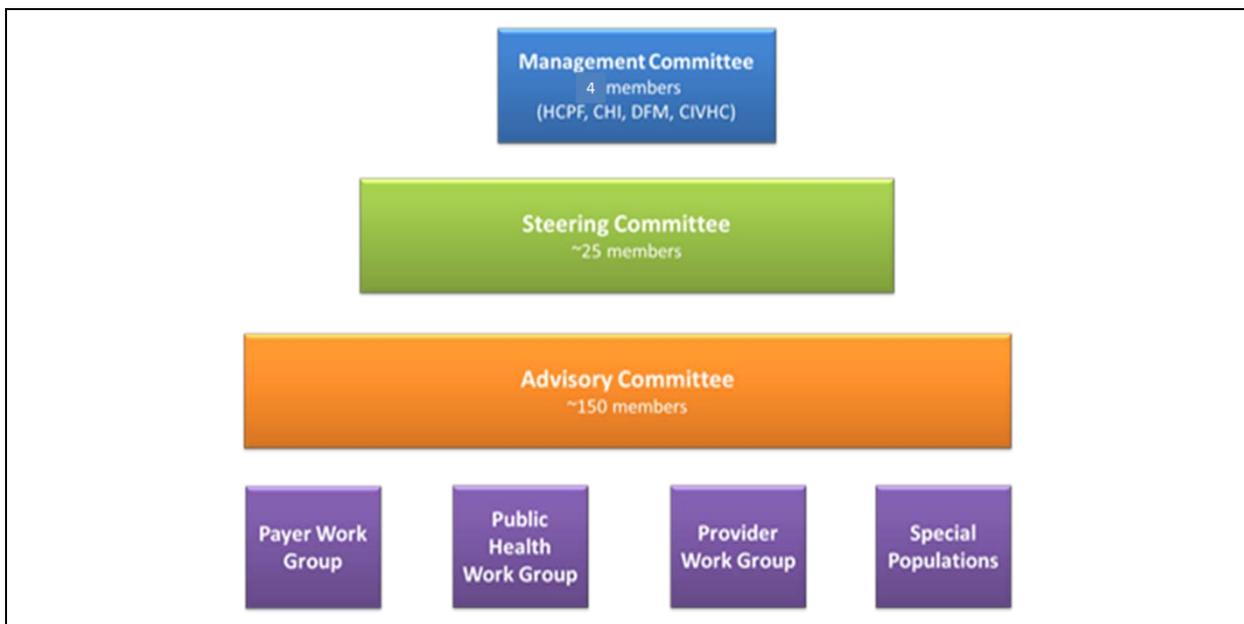
7.2 Planning Infrastructure and Process

Colorado's planning infrastructure and process involved a broad range of stakeholders from the public, nonprofit, and commercial sectors. HCPF, which is the state Medicaid agency, was the lead entity, but much of the activity carried out under the Initiative—including meeting preparation and facilitation, stakeholder engagement, and Plan drafting—was carried out by contractors. A significant majority of stakeholders were satisfied with both the scope and the level of stakeholder engagement and were generally supportive of the state's vision. However, some concern was expressed over the level of engagement from commercial payers. Several were uncertain whether a critical mass of insurers would be willing to participate in implementing the final Plan, despite state efforts to include them in its design.

Governance and management. HCPF contracted with 18 organizations to perform various tasks related to Plan development, but they worked particularly closely with three organizations: CIVHC, CHI, and DFM. CIVHC is a health policy organization founded in 2008 by an Executive Order of the Governor. Although once part of HCPF, CIVHC has operated as an independent nonprofit organization since 2011. It manages the state’s APCD and serves as convener for health policy discussions and collaborations between the public and private sectors (CIVHC, 2014b). CHI is a health policy research firm that focuses on coverage and access issues in the state (CHI, 2014). DFM has extensive expertise in care integration and leads the integrated care pilot Advancing Care Together, among other initiatives (University of Colorado, 2014).

The four-person central management committee for the Initiative, which included representation from HCPF and from these three entities, was responsible for day-to-day coordination and communication (see *Figure 7-1*). Other state agencies, including the Colorado Department of Public Health and Environment (CDPHE), the Office of Behavioral Health, and the Governor’s Office, were represented in one or more of the committees and work groups. Aside from the staff time devoted to administering the SIM Initiative, the state allocated no additional state resources to support activities but used the majority of the CMS SIM Pre-test award to support contractor activities.

Figure 7-1. Colorado SIM Model Pre-test planning infrastructure



Stakeholder engagement. Colorado has an established history of using stakeholder engagement to inform its health system transformation process. The 2006 Blue Ribbon Commission for Health Care Reform, for example, was a major multi-stakeholder process that

produced several recommendations later adopted by the state legislature, including a Medicaid eligibility expansion and establishment of a health insurance marketplace (State of Colorado, December 2013). The state was able to draw significantly on those existing relationships for putting together the initial proposal for a SIM Model Test award in 2012. Many of the key stakeholders involved in that application also participated in further developing the Plan under the Pre-test award. However, several interviewees noted that Plan development during the Model Pre-test process was more inclusive and involved a broader array of stakeholders. This was attributed both to CMS feedback on the original Model Test award proposal and to the relatively longer timeframe available.

Stakeholders were primarily engaged through face-to-face meetings, although information was also circulated electronically or made available on the state's SIM Web site (<https://sites.google.com/a/state.co.us/sim-colorado/>). A draft Plan was posted for public comments on this Web site in November, and a copy of the final Plan submitted to CMS was posted in December. In addition to the central management committee, which met weekly, the planning infrastructure also included: (1) a steering committee made up of roughly 25 key stakeholders, which helped prioritize or align conflicting recommendations from the work groups and provided specific input on the Plan as it developed; (2) an advisory committee of roughly 150 stakeholders, which provided more general feedback and helped create buy-in among their respective constituencies; and (3) four work groups that provided targeted input and feedback on specific subject areas (providers, payers, public health, and children and youth). CHI organized and facilitated the provider work group, while CIVHC oversaw the public health work group. HCPF staff took the lead on the children and youth group, and also led conversations with payers—which primarily included a handful of small and large payers HCPF deemed to be more focused on primary care and care coordination (State of Colorado, November 2013). Some key organizations, such as CDPHE and the Colorado Behavioral Healthcare Council (CBHC), were represented in multiple work groups and committees. Key focal populations targeted by the Plan included the state's tribal and homeless populations, although these latter two populations did not have formal work groups focused on their care needs. Instead, the state contracted with the Colorado Coalition for the Homeless and the Metro Denver Homeless Initiative (MDHI) to develop Plan strategies related to integrating care for the homeless (MDHI, September 2013), while the Lieutenant Governor's Colorado Commission on Indian Affairs (CCIA) consulted with the state's two Indian tribes to develop Plan strategies for their populations (CCIA, August 2013).

Just as with CIVHC, CHI, and DFM, many of the key stakeholders engaged through these committees and work groups were also contractors tasked by the state with developing specific input to the Plan. For example, the state contracted with CBHC to collect baseline information about current data-sharing arrangements in place between RCCOs and BHOs, which currently manage behavioral health services for the Medicaid population (CBHC, August 2013).

CORHIO and QHN drafted the Plan chapter on health IT (State of Colorado, August 2013). For the most part, stakeholders not directly contracted by the state served solely as Plan reviewers.

With a few exceptions, most interviewees were satisfied with both their level of involvement in Plan development and the state’s willingness to incorporate their feedback. Stakeholders in the behavioral health community were disappointed that the Plan paid relatively little attention to primary care integration into the behavioral health setting, focusing instead on the integration of behavioral health into the primary care setting. Some members of the steering committee voiced concerns over the level of payer engagement in the Plan development process. Although the state made efforts to include commercial payers, it was not clear to some stakeholders whether there will be enough buy-in to ensure that reforms reach 80 percent of the population. National carriers were seen as being more challenging to engage—as juggling the demands of operating in multiple states and, therefore, tending to be less flexible in their decision-making process. A similar point was made with regard to Medicare. Colorado is involved in several federally funded initiatives, and has found it challenging to develop a Plan that aligned—or at least did not conflict—with the requirements of those existing CMS initiatives.

7.3 The Colorado Plan

The Plan includes specific payment and delivery models, strategies, and policy levers to support the state’s ultimate goal of ensuring that 80 percent of Coloradans have access to “coordinated systems of care that provide integrated behavioral health care in primary care settings” by 2019. The state sees the Plan as a starting point on a path to creating statewide ACO-like systems of care that also integrate public health, oral health, LTC, and social and community support services. These ACO-like systems of care will gradually transition from FFS plus care coordination payments toward prospective global payment systems that align across public and private payers.

7.3.1 Models and Strategies

All the innovations proposed in the Plan support the broader goal of ensuring access to coordinated, fully integrated systems of care. These innovations include: (1) an ACO-like delivery model built on a foundation of integrated medical homes, (2) infrastructure to support practice transformation and population health, (3) workforce development, and (4) enhanced health IT and data analytics capacity. The specific models and strategies proposed all fall within these broader categories. [Appendix Table 7A-1](#) provides a summary description of the innovations proposed in each category, initiatives on which they are built, populations they address, policy levers proposed, and implementation entities.

ACO-like and PCMH models. The Plan proposes coordinated, ACO-like systems of care that integrate the full spectrum of physical, behavioral, public health, oral health, LTC, and community and social support services. As a starting point in the transition to these fully integrated systems, the state plans to focus initially on integrating behavioral health into the primary care setting, largely through continued development and expansion of PCMH. This is an approach the state refers to as the Colorado Framework. The Plan is not prescriptive as to the precise administrative structure of the broader ACO-like systems and leaves open the question of how the state is to create them. Instead, the primary focus of the Plan is implementation of the Colorado Framework.

The starting point for behavioral health and primary care integration is to be the state's existing PCMH foundation and the integrated care programs already under way, particularly those operating within the state's ACC Program and the CPCI. To support this transitional path, the state proposes a payment reform "glide path," which begins with FFS plus care coordination payments and gradually transitions to prospective PMPM payments, with some element of shared savings and risk-bearing. This payment model is geared toward the primary care providers who are the initial focus of the Plan. The state's ultimate goal is a prospective global payment that will support the broader vision of ACO-like coordinated systems of care, although the details of this transition are not explicitly defined.

The Plan outlines a primary care/behavioral health "integration continuum" modeled after the Agency for Healthcare Research and Quality Lexicon for Behavioral Health and Primary Care Integration, and includes three basic categories of service integration: coordinated, co-located, and integrated (Peek et al., 2013). The ultimate goal is for practices to have a behavioral health provider onsite and operating as part of the primary care team. To account for population variation and differing levels of practice readiness, the state has defined two scopes of integration. In the first, primary care practices focus on those behavioral health conditions (Scope I services) that commonly present in primary care (e.g., anxiety, depression, Attention Deficit Hyperactivity Disorder, risky substance use). In the second, practices will be able to provide Scope 1 services and also to identify and treat more complex patients presenting with co-occurring behavioral health and chronic conditions. The state has also (1) identified the key elements and competencies that practices will need to implement (such as team-based care and enhanced data analytic capacity) to move along the integration continuum, and (2) highlights the special needs of three subpopulations: the homeless, tribal populations, and children and youth.

Infrastructure to support delivery system transformation. The vision for supporting practice transformation goes beyond payment method. The state also proposes to implement an HES that will provide a range of services, including assessing practice readiness for integration, connecting those practices with the resources and technical assistance they require, and linking them with insurers once they have met the readiness criteria outlined in the Plan. The HES is

currently under development by a broad range of stakeholders, including DFM, CIVHC, and CDPHE. It builds on the concept of a Primary Care Extension Service described under Section 5405 of the Patient Protection and Affordable Care Act, but focuses on connecting practices to a broader range of community resources. The HES is also to be a key mechanism for connecting the public health system more directly with clinical care, by linking practices to local public health resources and other community and social supports.

Workforce development. The Plan’s workforce development strategies include building a more detailed knowledge base about the state’s current workforce needs; improving recruitment, training, and retention of a range of health personnel; reducing regulatory and policy barriers to collaboration between physical and behavioral health personnel; and broader deployment of paraprofessional public health workers, such as community health workers and patient navigators.

Enhanced health IT and data analysis. The state proposes to build on its existing health IT and data infrastructure through seven broad strategies: (1) promoting adoption of health IT tools that facilitate the provision of integrated care; (2) broadening provider connection to the state’s HIE and developing the HIE’s capacity to exchange both physical and behavioral health patient data; (3) developing and deploying training criteria on data sharing and privacy regulations; (4) improving and aligning state agency health IT efforts; (5) seeking ways to revise state and federal regulations around information sharing and patient consent; (6) developing better linkage of the public health system to existing HIE infrastructure; and (7) investing in rural and frontier health IT capacity, including telehealth.

7.3.2 Policy Levers

Existing and proposed policy levers for Plan implementation are listed in [Appendix Table 7A-1](#). The key policy levers identified in the Plan include a Round 2 Model Test award and a mix of additional state legislative, executive, and regulatory actions; and voluntary action in the nonprofit and private sectors. However, many of the tasks detailed in the Plan do not have a clear policy lever. Where a policy lever is described, it tends to involve building on initiatives and infrastructure already in place. CIVHC developed an extensive inventory of these activities, which is included in the Plan. Certain initiatives, however, are of greater relevance to Plan implementation. The CPCI, for example, is mentioned several times throughout the Plan as a starting point for aligning quality measures and payment methods across payers. The state also proposes to expand its existing ACC initiative to encompass the entire Medicaid population and will pursue a Section 2703 Health Homes state plan amendment (SPA) to develop integrated care within behavioral health settings for beneficiaries with serious mental illness. The Plan does not propose any additional federal waivers or SPAs, although it acknowledges that such action may be necessary as the state begins to implement its broader ACO-like model.

The Plan also identifies several short- and long-term changes that will need to occur at both the state and federal levels to support the transition to integrated care—particularly those related to information sharing, regulation and oversight of behavioral and physical health providers, and the various funding streams that support service provision. However, it does not lay out specific policy levers it will pursue to address these needs; rather, it proposes to assess the state’s existing legal and regulatory framework and conduct a survey of other states’ systems to identify best practices in building a legal infrastructure that can support integration. If needed, the state may then take steps to revise those laws and regulations.

Aside from leveraging the work being done under the multi-payer CPCI, the Plan also does not detail how the commercial sector will align with the payment model being proposed, although the implication is that this will occur through voluntary action. Neither does the Plan describe how the HES infrastructure to support practice transformation will be funded, although the Plan notes that this initiative is currently under development.

7.3.3 Intended Impact of the Health Care Innovation Plan

Aside from the previously noted goals related to integration and care coordination, the Plan outlines several other intended outcomes. Specifically, the state aims to improve overall performance on chronic disease and behavioral health indicators, reduce and maintain the average annual growth rate of health care spending to or below the rate of overall inflation, and improve patient experience with health care services. The specific evaluation measures it plan to use have not been finalized, but are to align with existing measures for initiatives already under way in the state, particularly the ACC Program and CPCI. No stakeholders expressed serious doubts over the Plan’s potential to reach 80 percent of the population. Doubts that were expressed centered on issues related to feasibility, because reaching 80 percent of the population will require broad buy-in from the commercial sector and significant state and federal investment.

7.3.4 Proposed Next Steps

Colorado will pursue a Round 2 Model Test award, but the Plan indicates—and state officials confirmed—that the state will attempt to implement the Plan regardless of whether it receives this funding. However, if such funding is not forthcoming, the state will be obliged to implement the Plan’s recommendations on a phased or partial basis. Colorado has several foundations that can provide limited grant funding to support these efforts.

The Plan does not describe a specific management structure for Plan implementation, although it does state that primary ownership of the Plan is to rest with the administration, with ongoing support from stakeholders.

7.4 Discussion

Colorado's Plan was heavily influenced by the original SIM Model Test award proposal process. Participating stakeholders in the Model Pre-test development process were asked to identify the elements or strategies that were missing from the model developed under the earlier process, rather than to propose new models. This approach to Plan development was seen as an essential strategy for streamlining the consultation process and managing the flow of information between the state and external stakeholders. The structure of the various committees and work groups also facilitated the communication process—by allowing the state to get detailed input from key stakeholders in the steering committee and work groups while also increasing buy-in through broad engagement of the advisory committee.

Stakeholders commented that addressing some of these barriers may be politically difficult, particularly those relating to the state's Medicaid managed behavioral health care program. Overall, however, Colorado implemented a multi-stakeholder engagement process that ultimately produced a Plan that was broadly supported stakeholders.

7.4.1 Critical Factors That Shaped the Health Care Innovation Plan

The key proximate factor shaping both the development and final contents of the Plan was the momentum created by the initial SIM Model Test award application in 2012. Although the final Plan includes many new elements and involved a broader array of stakeholders than the original proposal, the central goal is essentially the same: to integrate behavioral health into the primary care setting as part of a first step in building fully integrated care systems. The momentum behind this goal was built on several contextual factors, including a generally supportive political environment and broad agreement in the policy community that care integration is a desirable goal. Both the Governor's Office and the legislature have taken an active role in health care reform. The state voted to expand Medicaid and establish a state-based health insurance marketplace, among many other efforts. One stakeholder reported that this focus area was directly informed by the original SIM testing proposal.

The new elements of the Plan—which include a greater focus on health IT, details on practice transformation and payment reform processes, an increased role for the public health system, and specific considerations for the needs of special populations—reflect both informal feedback from CMS on the original Model Test proposal and the state's Plan development process, which involved a broader range of people. The steering committee, advisory committee, and work group meetings allowed stakeholders multiple opportunities to provide feedback, but much of the actual drafting of the Plan was done by contractors—CHI, CIVHC, and DFM, in particular—with specialized experience or skill sets.

Some of the people involved in the Model Test application noted that the Plan developed in this round benefited significantly from the longer timeframe afforded to states, because it provided more opportunity to engage with a wider range of stakeholders. However, one of the key Plan developers noted that the timing and frequency of stakeholder engagement was not ideal for a truly collaborative process, and that the steering committee in particular could have been engaged both sooner and more frequently. The structure of the Plan development process meant that the steering committee meetings were designed primarily to review rather than build the Plan. Nevertheless, the majority of people on the steering committee were satisfied with their level of involvement and expressed support for the final product.

7.4.2 Lessons Learned

The Plan development process in Colorado yields several lessons:

- **Building on an existing plan can facilitate the development process, but may also limit the ability of stakeholders to substantially influence its final form.** The state entered the development process with an existing framework, and although the final Plan includes a number of additional elements, integration of behavioral health into primary care remained the central goal. Stakeholders made it clear that no other models or strategies were solicited or considered—that they were told the key concepts were already developed and vetted, and their role was to comment on things that were missing. One contractor noted that, given the timeline for the initiative and the complexity of the issues under discussion, this approach was necessary to reduce confusion and ensure the state met its deadlines. All 17 interviewees supported the Plan and its aims, but some state officials (all working outside the Medicaid office) and provider representatives noted that the focus on primary care integration left less room to fully develop models and strategies for other forms of integration (such as the integration of primary care into the behavioral health setting). Although they agreed that care integration in the primary care setting is an important goal, they expressed regret that their contributions to the Plan were not as substantial as they would have liked.
- **Effectively managing the communication process is challenging and time-consuming, but integral both to meaningful stakeholder engagement and to obtaining buy-in.** Many of the challenges cited by stakeholders were linked to communication issues, which arose both between CMS and the state, and between the state and external stakeholders. Between CMS and the state, the communication issues centered around how CMS was defining concepts such as goals, aims, models, and drivers. Some of the key staff involved in developing the Plan reported initial confusion over these various concepts and how they related to each other, and that this confusion posed challenges for them as they attempted to communicate with other stakeholders about the Plan. Between the state and external stakeholders, issues mostly related to the challenge of communicating often complex topics to a wide range of audiences, and managing the flow of information obtained through the various work groups and committees. However, this process was seen as being

essential to creating buy-in and resulted in a much stronger proposal for reforming the state's health system.

- **The structure of the stakeholder engagement process can help to balance the need for broad consensus with the need for detailed and specialized input.** Given the difficulty of engaging with more than 150 individuals and organizations within a defined timeframe, the state structured its consultation process with the 25-person steering committee acting as an intermediary between the five-member management committee that oversaw day-to-day activities and the large advisory committee that provided broad stakeholder feedback about the Plan. The steering committee was made up of individuals and organizations—such as CDPHE, Office of Behavioral Health, Colorado Medical Society, and Colorado Hospital Association—that have a higher level of health policy knowledge than other stakeholders engaged through the advisory committee and provided more detailed feedback on the Plan. The advisory committee served as more of a forum for publicizing the Plan and creating buy-in from the larger policy arena.
- **The state is a key player in the development and implementation of major reform efforts, but is limited in its ability to impact national payers and, by extension, 80 percent of the state's population.** For the most part, stakeholders thought the state was the appropriate entity to lead development of a Plan for health care innovation. Those who raised doubts (four of the 17 we spoke with) were located outside the Medicaid office, and all noted that it is difficult for the state to drive change when it covers a relative minority of the population. The willingness of private payers to align their efforts with those under way in the state, according to the same four, depends on several factors, some of which are outside state control. National insurance carriers' need to balance the demands of operating in multiple states was noted as a factor making them somewhat less flexible than state-based carriers—a problem, according to these interviewees, that is compounded by the need to align state activities with federal payment and delivery reform efforts already under way.

7.4.3 Potential for Implementation

All stakeholders thought the Plan was feasible—albeit ambitious—but none thought full implementation would be possible in the absence of federal funding. Even with a Model Test award, they said, other resources will need to be tapped, such as foundation funding and private payer investment. A few went further to note particular challenges that may affect Plan feasibility.

First, and as noted throughout this report, they say it is not clear at this stage how many commercial payers will commit resources to Plan implementation—that even within Medicaid, payment reform will be problematic, owing largely to the state's behavioral health carve out. The need to rethink the current BHO reimbursement system was raised in both steering committee meetings and interviews—with one interviewee citing it as the number one barrier to care

integration in the Medicaid program. Integrating payment for behavioral health and primary care services will require substantial changes to the BHO infrastructure, according to stakeholders, and there was some concern that the disruption could negatively affect services for the severely mentally ill, who typically receive the majority of their services through specialty providers rather than primary care. In the final steering committee meeting, the state raised the possibility that it would reconsider the carve-out system in the future, but this issue proved controversial. Although the final version acknowledges the barriers created by the current behavioral health carve-out system, it does not directly propose to change it.

Aside from the issue of payment reform, several stakeholders noted that practice transformation is difficult even in the context of adequate resources. Successful implementation will depend not only on establishing the HES, they said, but on there being enough providers willing and able to transform. Other outstanding questions include the upcoming Governor's election and the effect that it may have on implementation. However, none of the people we spoke to expressed serious concern about this.

7.4.4 Applicability to Other States

The proposed models and strategies in the Plan are potentially transferrable to other states, although as with any reform there may be factors that facilitate or complicate efforts to generalize to a different context. One issue stakeholders felt was particular to Colorado was the state's relatively long history of broad engagement around health reform, most notably the 2006 Blue Ribbon Commission for Health Care Reform and the CPCI. The existing relationships among these various stakeholders were a central factor shaping both the development and final form of the Plan, and one interviewee speculated that states without these existing connections would have a more difficult and drawn-out development process.

7.4.5 Influence of Pre-Test Status

The Pre-test status was, as noted throughout, the most influential and critical factor underpinning the planning process and the shape of the final Plan. Several respondents noted that having more time to develop and refine the Plan through the pre-test development period was useful and resulted in a much stronger vision for the state.

7.4.6 Limitations of This Evaluation

We were unable to attend committee meetings in person, which may have limited our understanding of the dynamics at play in the state. We also concentrated most of our interviews among the state officials and organizations that were heavily involved in drafting the Plan, which may have precluded a better understanding of how the process was perceived by organizations less involved in its development.

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Appendix Table 7A-1. Models and strategies proposed in the Colorado Health Care Innovation Plan

| Model type or strategy | Preexisting model, program, or initiative that Plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|---|---|--|--|---|
| <p>ACO-like and PCMH models Establish coordinated systems of care that integrate physical health, behavioral health, public health, oral health, and long-term services and support</p> <p>Statewide adoption of integrated behavioral health and primary care through PCMH models that include various scopes of behavioral services</p> | <p>Medicaid ACC Program, CPCI</p> | <p>General population, with specific integration strategies for children and youth, homeless, and tribal populations</p> | <p>Existing SB 09-259, which established the Medicaid ACC</p> <p>Build on payment reform efforts under way through the CPCI</p> <p>Proposed state legislative actions *Expand the ACC Program to cover the entire Medicaid population</p> <p>Proposed executive branch actions *Pursue Section 2703 Medicaid Health Homes SPA for Medicaid enrollees with severe and persistent mental illness</p> <p>Proposed federal action Seek federal approval for Medicaid to move away from fee for service while maximizing hospital provider fees</p> <p>Round 2 Model Test award</p> | <p>HCPF, CDPHE, RCCOs, BHOs, commercial payers, providers</p> |
| <p>Infrastructure to support delivery system transformation Implement a Health Extension System statewide</p> <p>Connect the public health system with clinical care</p> <p>Develop reimbursement strategies to support public health</p> | <p>Health Extension System</p> | <p>N/A</p> | <p>Existing Implement the Health Extension System currently under development in the state</p> <p>Proposed federal action Round 2 Model Test award</p> | |

(continued)

Appendix Table 7A-1. Models and strategies proposed in the Colorado Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that Plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|---|---|-----------------------|---|--|
| <p>Workforce development Strengthen the base of workforce data to aid decision-making</p> <p>Improve recruitment, retention, and training of health professionals</p> <p>Address policy barriers to workforce innovation and workplace satisfaction</p> <p>Expand existing innovative workforce efforts</p> | Health Extension System | N/A | <p>Existing HB 12-1052, which authorizes the state to request workforce data from providers when they renew their licenses</p> <p>*Leverage the Health Extension System currently under development to connect providers to training resources</p> <p>Proposed executive branch actions *Review current laws and regulations regarding provider credentialing and other workforce issues to identify areas for change</p> <p>Launch a statewide campaign to educate providers on incorporating a behavioral health specialist in primary care practices</p> <p>Proposed federal action Round 2 Model Test award</p> | HCPF, CDPHE, RCCOs, BHOs, commercial payers, providers |

(continued)

Appendix Table 7A-1. Models and strategies proposed in the Colorado Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that Plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|---|---|-----------------------|--|---|
| <p>Enhanced health IT and data analysis Promote adoption of health IT tools that can support integrated care Leverage the state HIE to promote integrated care Link the public health system to the state HIE Improve understanding of data sharing and HIE statewide Align health IT efforts across state agencies Address legal and regulatory barriers to information sharing Conduct rural outreach</p> | <p>CORHIO, QHN, APCD, SDAC, FeHITO, Colorado TeleHealth Network</p> | <p>N/A</p> | <p>Existing Support efforts by the Public Health Information Exchange Steering Committee to connect existing public health databases to the state HIE *Build on existing efforts under way through CORHIO, QHN, Colorado TeleHealth Network, and FeHITO Proposed executive branch actions Reestablish a public/private health IT Planning Committee to develop new ideas, standards, and recommendations for health IT implementation *Pursue 90-10 HITECH FFP and MMIS matching funds to support interoperability between state agencies and statewide HIE, and electronic health record adoption and meaningful use Proposed federal action Round 2 Model Test award</p> | <p>CORHIO, QHN, HCPF, state agencies, insurers, providers</p> |

¹Policy levers include Medicaid waivers; federal grants (including Round 2 SIM award); state laws; state regulations; state investments (e.g., in public health programming); foundation grants; employer-led coalitions to drive change among providers, purchasers, or plans; state government-led coalitions, task forces, or commissions to drive voluntary change among providers, purchasers, or plans; state purchasing contracts; and state-level (Governor-initiated) executive policy directives.

Abbreviations: ACC = Accountable Care Collaborative, ACO = Accountable Care Organization, APCD = All-payer claims database, BHO = Behavioral Health Organization, CDPHE = Colorado Department of Public Health and the Environment, CORHIO = Colorado Regional Health Information Organization, CPCI = Comprehensive Primary Care Initiative, FeHITO = Federation of Health Information Technology Organizations, HCPF = Department of Health Care Policy and Finance, HIE = health information exchange, HITECH FFP = Health Information Technology for Economic and Clinical Health federal financial participation, MMIS = Medicaid Management Information Systems, N/A = not applicable, PCMH = patient-centered medical home, QHN = Quality Health Network, RCCO = Regional Care Collaborative Organization, SDAC = Statewide Data and Analytics Contractor, SPA = state plan amendment.

8. Connecticut

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Important contextual factors influencing Connecticut’s Health Care Innovation Plan (the Plan) include the state’s per capita health care spending (among the highest in the nation and rising); an already functioning all payer claims data base (APCD); existing medical home initiatives; health disparities across the state; and an established value-based insurance design (VBID) component of the state employees’ health plan.

The Lieutenant Governor led the Model Design process, and appointed and oversaw the core leadership team, which was led by the head of the Office of the Healthcare Advocate and included the Medicaid administrator within the Department of Social Services and a lead staff person from the Department of Mental Health and Addiction Services. The state leaders of the planning process formally invited fewer stakeholders to serve on committees or work groups, and then periodically shared results and solicited broader input (including through direct stakeholder engagement).

The Plan proposes innovations in three main categories: primary care practice transformation through an Advanced Medical Home (AMH) model, community health improvement initiatives, and consumer empowerment initiatives. Four enabling initiatives would support these innovations: performance transparency, value-based payment, health information technology (health IT) investment, and health care workforce development.

The Plan outlines four implementation phases that will occur over 5 years—a 9-month detailed design phase, a 9-month implementation planning phase, an initial 1-year implementation phase (to include the launch of most innovation plans), and subsequent scale-up to be complete by June 2020. Levers noted in the Plan include executive, regulatory, and legislative authorities, many of whose details have not yet been set. A Medicaid waiver or state plan amendment (SPA) is proposed to expand the PCMH program and help make incentive payments consistent with payment and delivery system reforms.

8.1 Context for Health Care Innovation

Connecticut undertook its State Innovation Model (SIM) effort in the context of: (1) increasing health care spending in the state, (2) state investments in health IT initiatives and an all-payer claims database (APCD), (3) state investments in medical home initiatives, (4) disparities regarding health care coverage and outcomes, and (5) experience implementing VBID

in the state employees' health plan. This context influenced the perspectives and priorities of stakeholders involved in developing the Plan and its content.

Connecticut has higher health care spending per capita than almost all other states. In June 2010, Connecticut was the first state in the nation to opt to expand Medicaid coverage under the Patient Protection and Affordable Care Act. This expansion is expected to significantly increase total Medicaid spending (State of Connecticut, 2013). Stakeholders said that Connecticut identifies the SIM Initiative as an opportunity to improve quality while reducing health care spending, especially spending related to high-cost individuals and high rates of emergency department use and hospital readmissions.

Connecticut launched the Health Information Technology Exchange of Connecticut (HITE-CT), which is designed to share health information across all providers to promote improved quality of care (HITE-CT, 2013). However, stakeholders considered Connecticut to be in the bottom half of states in terms of adopting electronic health records (EHRs) and electronic prescribing, and identified the SIM Initiative as an opportunity to make substantial improvements in this area. In addition, Public Act 12-166 recently authorized creation of an APCD to receive protected health information from some carriers via state mandate, and others via contract or other means—including Medicaid and Medicare Parts A and B fee for service.

Connecticut has used state policies to advance a patient-centered medical home (PCMH) model since 2009, when the state mandated that health plans administering the state employee self-insured health insurance program offer a PCMH program based on National Committee for Quality Assurance (NCQA) standards. In 2011, Connecticut established a Medicaid PCMH program. Under this program, primary care practices participate in a “glide path” model that provides financial support in the form of enhanced fees in the following sequence: (1) while they are on the glide path, (2) upon achieving medical home recognition through the Joint Commission or NCQA, and (3) once they achieve quality and patient experience performance targets. Other commercial health plans in Connecticut also have medical home initiatives, each with their own standards and payment models (State of Connecticut, 2013). Stakeholders explained that the state's existing medical home initiatives focus on individual practices, and identified the SIM Initiative as an opportunity to promote development of AMHs that aggregate these solo practices into such organizational structures as independent practice associations (IPAs), accountable care organizations (ACOs), or clinically integrated networks.

During focus groups conducted as part of consumer outreach under the SIM Initiative and under other state reforms, Connecticut consumers identified lack of affordability and lack of coverage for some services as their main barriers to receiving appropriate health care. Lack of affordability and coverage disproportionately affects minority populations in Connecticut. Only 50 percent of African Americans and 33 percent of Hispanics have employer-sponsored health insurance, for example, compared to 65 percent of whites and 63 percent of Asians. Although 16

percent of African Americans and 30 percent of Hispanics receive insurance through public safety net programs, many minorities purchase individual plans or remain uninsured (State of Connecticut, 2013).

Finally, 98 percent of eligible employees and retirees in the state employees' health plan voluntarily participate in its Health Enhancement Program, a value-based insurance design (VBID) initiative that provides financial incentives to covered individuals for maintaining a minimum schedule of well-visit and screening visits, and disease-specific education and counseling for those living with one of the target chronic diseases. This program, in place since 2011, has experienced positive changes in cost trends to date. Additionally, several other large employers in Connecticut have implemented VBID (State of Connecticut, 2013).

8.2 Planning Infrastructure and Process

The state both created additional planning infrastructure, including the State Health Care Innovation Plan Steering Committee (Steering Committee) and work groups, and leveraged existing infrastructure such as its Health Care Cabinet, established in 2011 to advise the executive branch on issues related to implementation of federal health reform and development of an integrated health care system for the state.

Executive leadership commitment. Lieutenant Governor Nancy Wyman was a highly engaged leader of, and champion for, the SIM Model Design process. She was once a health care provider, more recently a purchaser in her former role as State Comptroller, and an advocate for improving health care access and affordability. She appointed and oversaw the SIM Initiative core leadership team (core team), chaired the Steering Committee, and formally appointed each member of the three work groups. Stakeholders also noted a firm commitment from Governor Dannel P. Malloy, his health policy staff person, and numerous state agencies.

State SIM leadership. The core team comprised a project director and two associate directors. The project director was the State Healthcare Advocate, who leads the Office of the Healthcare Advocate; the associate project directors were the Medicaid administrator within the Department of Social Services and one lead staff person from within the Department of Mental Health and Addiction Services. The core team led the Model Design process and made day-to-day procedural decisions under the Lieutenant Governor's oversight. They presented design-related material to the Health Care Cabinet on a monthly basis, to obtain input on model development and feedback on the stakeholder engagement strategy. Stakeholders spoke very highly of the core team, noting their vision and commitment. The core team noted that they did not seek or require input or authority from the legislature during the planning process.

Steering Committee. The Lieutenant Governor formally appointed members of a Steering Committee to guide the core team on issues of key strategic, policy, and programmatic

concerns. In most cases, the core team identified candidates for the Steering Committee; less frequently, candidates became aware of the process and asked to be included. In all cases, the Lieutenant Governor reviewed recommendations and formally approved members. The committee included Commissioners from seven state departments; the Dean of the School of Medicine from the University of Connecticut Health Center; and high-level representatives from payers, providers, employers, foundations/advocacy/community organizations, and Connecticut's health insurance marketplace. The core team reported at least monthly to the Steering Committee. Two consumer advocates were added to the Steering Committee in November 2013 (see below for additional discussion). Finally, five state agencies with a major role in overseeing or delivering health care each assigned a dedicated program planner to support the core team and Steering Committee's SIM Initiative effort.

Work groups. Connecticut established three formal SIM Initiative work groups: care delivery, payment reform, and health IT. As with the Steering Committee, the Lieutenant Governor formally appointed representatives from key stakeholder groups to participate in these work groups. Most Steering Committee members participated in at least one work group and additional members were drawn from a broad array of stakeholders.

Two other groups supplemented the efforts of the Steering Committee, core team, and work groups. First, under the auspices of the SIM Initiative, the University of Connecticut Health Center and the state Department of Public Health launched a taskforce to assess the state's current provider landscape and propose workforce changes required to support the new care delivery and payment model. Second, midway through the design process, the core team convened three meetings with health equity stakeholders to gathering feedback. As evidenced by email discussions outside these meetings, this ad hoc work group was actively engaged and committed to the process. Feedback from this group catalyzed the prominence of health equity in the Plan.

Stakeholder engagement and public forums. *Table 8-1* lists the broad range of stakeholders involved in the Model Design process and how frequently they were engaged. The state made a conscious decision to formally invite fewer stakeholders to serve on the Steering Committee and work groups, and to periodically share results of these meetings more broadly with a wide range of stakeholder groups. The core team and some members of the Steering Committee and work groups perceived this choice as efficient and effective, although some stakeholders—particularly those in the consumer advocate group—felt excluded from the process. Also, some engaged stakeholders of other types expressed concerns that their peers were not aware of or invested in the process. They suggested that improvements in communication could have alleviated these challenges.

Beyond the formal planning infrastructure, the state engaged the public through a three-phased strategy designed by the core team with advice from the Health Care Cabinet, Steering

Committee, and a consultant. The three phases included: (1) an input phase using listening sessions and electronic surveys to identify health care problems and solutions, (2) a model feedback phase in which the work group recommendations and emerging model were shared, and (3) a Plan syndication phase that solicited feedback on the detailed Plan. In general, the strategy favored joining existing stakeholder groups and forums rather than holding town hall meetings and public hearings, because the state believed the former to be more conducive to sharing personal experience and meaningful dialogue. By the end of December, the SIM Initiative planning team had met with more than 50 stakeholder groups (see [Table 8-1](#)).

Table 8-1. Stakeholder participation

| Stakeholder groups | Number of meetings or events |
|--|------------------------------|
| Health Care Cabinet | Ongoing |
| Care Delivery Work Group: Consumers, clinicians, community organizations, state agencies, employers, payers | 8 |
| Payment Reform Work Group: Clinicians, hospitals, community organizations, state agencies, employers, payers | 7 |
| Health IT Work Group: Clinicians, community organizations, state agencies, payers, IT specialists | 5 |
| Public and private payers, self-insured employers, business groups on health | 7 |
| Social service and faith-based organizations, representatives of health education and community health organizations | 5 |
| Consumers, including seniors, mothers, Medicare- and Medicaid-insured, commercially insured, uninsured, people with insurance through self-insured employers, health care advocates, community leaders | 27 and one electronic survey |
| Health care providers, including medical, behavioral, developmental disability, substance abuse, and health centers; Area Agencies on Aging; long-term services and supports (LTSS) providers | 23 |
| State and local health agencies, tribal agencies, state health IT coordinators, and community service organizations | 7 |
| Funders and resource foundations; academic experts; external quality review organizations; hospital engagement institutes; health associations | 5 |
| Task force led by University of Connecticut and state Department of Public Health (on workforce) | Unknown |
| Health equity stakeholders | 3 |

During the model feedback phase, the Lieutenant Governor convened a special forum in response to a letter sent by 24 consumer advocates (Connecticut Consumer Advocates, 2013) expressing concerns about the transparency of the design process and particular Plan elements under consideration. The core team, Lieutenant Governor, and other stakeholders reiterated a commitment to a transparent process but acknowledged this group's concerns, in part, by adding two independent consumer representatives to the Steering Committee. In response to specific feedback on elements of the Plan, the core team incorporated several solutions into the proposed model. For example, an Equity and Access Council was proposed to develop methods to protect against adverse selection, access issues, and underservice; and consumer advocates will sit on a new Quality Metrics Council. Nevertheless, these changes did not appease some stakeholders.

Deliberation and decision-making. Several stakeholders characterized their participation in the Steering Committee or work groups as one of “reacting to a straw man.” Although the core team considered input from numerous stakeholders, deliberation and decision-making mainly occurred via iterative exchanges between the core team and the Steering Committee. Before each Steering Committee meeting, the core team shared slide presentations related to a model overview, a draft and a final Plan, among other issues. The core team responded in detail to Steering Committee comments made during and outside the meetings, summarized each issue, and made recommendations for discussion and consensus-building. The Plan states that, although “it was not practicable to bring all of the design decisions to the Steering Committee, it is fair to say that the Steering Committee supports the overall approach outlined in the Innovation Plan and that issues that were the subject of the most concern were resolved” (State of Connecticut, 2013).

State resources. The state committed extensive resources to the planning process. For example, stakeholders noted that none of the core team members was supported with SIM funds. Two of the core team members essentially worked two jobs: their role in the SIM Initiative and their “day job.” In addition, at least two key consultants supplemented state SIM Initiative capacity by providing significant support in such areas as design, financial analysis, and stakeholder engagement. The core team noted a definite need for additional staff support.

8.3 The Connecticut Plan

As the cornerstone of the Plan, Connecticut proposes to build on current PCMH initiatives to develop a health care delivery reform model focused on an AMH. The state would implement policies that set practice standards for provider entry to and participation in the AMH. The state would also enact regulation to remove barriers to participation in the AMH.

The Plan includes two additional primary drivers of innovation and four enabling initiatives that support these innovations. The state proposes to use its executive, regulatory, and legislative authorities to support implementation of these strategies and initiatives. Taken

together, these strategies and initiatives are to constitute a health care delivery system designed to reach at least 80 percent of the state's population within 5 years.

8.3.1 Models and Strategies

The Plan proposes innovations in three main categories: (1) an AMH model; (2) community health improvement initiatives, including infrastructure to support delivery system transformation and public health strategies; and (3) consumer empowerment initiatives. Connecticut proposes four enabling strategies to provide systems and resources to support its three innovations: (1) performance transparency, (2) value-based payment, (3) health IT, and (4) health care workforce development (State of Connecticut, 2013). Stakeholders noted that strategies related to LTSS and complex behavioral health issues were not incorporated into the plan. *Appendix Table 8A-1* provides an overview of the models and strategies proposed in the Plan, initiatives on which they are built, populations they address, and supporting policy levers and entities.

AMH model. Connecticut proposes an AMH model as the basis for achieving person-centered primary care that is coordinated across the health care delivery system. The Plan outlines a process by which all health plans would adopt a common set of standards (to be developed) that define AMH and, for practices not yet recognized as a PCMH, would avoid some of the complexities of existing PCMH recognition processes. The Plan makes clear that additional aspects of this model remain undecided, such as which clinicians would be eligible to become AMHs and the patient attribution model to be used.

As proposed, the AMH model has five core elements: (1) promote whole person-centered care by using simple assessment tools to understand the holistic needs of patients and coordinate care to meet these needs; (2) enhance patient access to care through such changes as expanded provider hours, same-day appointments, and e-consult access to specialists, and to community services offered by a designated Prevention Service Center (see below); (3) use population-based data to identify at-risk populations and develop interventions to reduce health equity gaps; (4) implement multidisciplinary teams across medical care and behavioral health care; and (5) use evidence on clinical outcomes and cost-effectiveness to inform clinical decisions. Connecticut designed a glide path, which is currently in use, to support practices that vary in their ability to meet the advanced AMH standards (State of Connecticut, 2013; also see value-based payment).

Infrastructure to support delivery system transformation. Connecticut plans to implement designated Prevention Service Centers, including new or existing community-based organizations, providers, or local health departments that provide evidence-based prevention services and meet other criteria, such as deploying community health workers. Prevention Service Centers, which are the mechanism by which primary care and public health services are

to be integrated, would initially focus on leading causes of hospitalizations, including diabetes, asthma, and injuries. Primary care practices would be able to refer patients to Prevention Service Centers as needed, which would draw on existing programs related to diabetes, asthma, and falls prevention (State of Connecticut, 2013).

Public health strategies. Connecticut plans to establish Health Enhancement Communities (HECs) in areas vulnerable to health disparities. HECs would meet a baseline of criteria and be cosponsored by the local health department and private sector entities to improve community health and reduce health disparities. Their role is to coordinate resources and promote partnerships across health and non-health-related entities—at the state and local levels—and focus on policy, system-level, and environmental interventions.

Consumer empowerment initiatives. The transformation to whole person-centered care would require consumers to be active participants in the management of their health. Connecticut plans to implement four strategies to promote consumer empowerment: (1) provide information to consumers and encourage them to engage in shared decision making with providers; (2) appoint consumers to roles in the governance structure; (3) incorporate consumer input through care experience surveys into value based payment initiatives; and (4) incentivize consumers for positive health behaviors by promoting value-based insurance designs and employer incentive programs (State of Connecticut, 2013).

Performance transparency. Connecticut’s stakeholders identified an understanding of quality, cost, and price as necessary to health care delivery and payment reform. To achieve performance transparency, Connecticut plans to implement four interventions. First, Connecticut would create a common scorecard for AMH providers to measure health status, quality of care, and consumer experience. Second, it would track primary care performance for quality, care experience, equity, and cost measures. Third, it would combine data across payers to analyze provider performance across patient panels. Finally, Connecticut would design reports to disseminate information to consumers, payers, providers, and policy makers (State of Connecticut, 2013).

Value-based payment. The Plan proposes to establish two options for value-based payment to providers around which all payers would align. The first option, Pay for Performance (P4P), is defined as “transitional.” The Plan states that commercial payers have agreed to support practices as they develop skills and infrastructure to become an AMH, similar to the payments Medicaid is making to providers under their current Glide Path model. The second model is a Shared Savings Program (SSP) for AMHs that meet certain criteria, including a panel size of 5,000 patients or more with each payer. Under an SSP, AMHs would receive fee-for-service (FFS) payments plus a reward, if the total health care cost for patients attributed to their practice was less than projected but still met standards for quality. In some cases (for payers other than Medicaid), AMHs could also face downside risk if the costs exceeded projections.

This model assumes exclusions and risk adjustments in the patient population and requires that AMHs be monitored for potential underservice. Connecticut would encourage payers to tie P4P and SSP to one common scorecard for quality, care experience, health equity, and cost (State of Connecticut, 2013).

Health IT. Connecticut plans to implement a health IT strategy based on four principles. First, the state would support advanced payer and provider analytics that improve care delivery and patient health, with the introduction of cross-payer, “aggregate” analytics through Connecticut’s APCD and health information exchange. Second, it would create a multi-payer portal for providers and consumers to facilitate access to information and better decision making. Third, Connecticut would provide guidelines for care management tools rather than mandatory procedures for adopting these tools. Finally, it would standardize its approach to clinical information exchange to accelerate providers’ use of direct messaging for secure communication and coordinated delivery across different sites (State of Connecticut, 2013).

Workforce development. The state plans to ensure it has a health care workforce of sufficient size, composition, and training to implement the Plan by promoting six initiatives. The first is to collect health workforce data and analytics to make informed decisions regarding training initiatives and regional needs. The second is to create a Connecticut Service Track to promote team and population-health approaches to health professional training. This initiative would build on Connecticut’s Urban Service Track program for community-based interprofessional training, established to serve disadvantaged populations in urban settings. The third initiative is to develop training and certification standards for community health workers. The fourth is to prepare providers to adapt to advanced and accountable care delivery models. The fifth initiative is to revise primary care graduate medical education and residency programs to better align with health care reforms. The final initiative is to work with Connecticut’s colleges and universities to improve science, technology, engineering, and math preparation for future health and allied health professionals; and to enable credit transfer across programs to improve career flexibility, expand the pipeline of health care professionals, and promote workforce diversity (State of Connecticut, 2013).

8.3.2 Policy Levers

This section outlines key policy levers presented in the Plan; additional policy levers the state may pursue to facilitate implementation are listed in [Appendix Table 8A-1](#). Connecticut plans to pursue a range of policy levers through its executive, regulatory, and legislative authorities that support implementation of the Plan’s three innovations and four enabling initiatives. Generally speaking, stakeholders were not aware of these proposed policy levers or the practical logistics of implementing the Plan, and many of the policy lever details have not yet been determined.

To support implementation of the AMH model, the Plan proposes that the executive branch establish an entity to define practice standards for provider entry to and participation in the model. The Plan also proposes that the executive branch seek a Medicaid waiver or SPA to broaden the scope of the PCMH program and align incentive payments with the payment and delivery system reforms (State of Connecticut, 2013).

To support infrastructure to improve population health and public health strategies, state legislative or regulatory changes would be necessary to implement the Plan. For example, the Plan proposes legislation or regulation to designate and provide resources for Prevention Service Centers and HECs (State of Connecticut, 2013).

To support implementation of consumer empowerment initiatives, the Plan proposes legislation or regulation that facilitates consumer access to the APCD. This same policy lever also supports implementation of performance transparency and health IT—building on existing state legislation, Public Act 12-166, that supports development of an APCD to receive protected health information from carriers (including public payer data such as Medicaid and Medicare).

Other proposed levers for performance transparency include: (1) legislation that supports transparency in health care price information for consumers and requires notice of acquisition of physician provider practices, (2) legislation or regulation to ensure payer reporting on public health and quality metrics used in the model, and (3) establishment of an entity to define practice standards for provider entry to and participation in the model (State of Connecticut, 2013).

Another proposed lever for health IT is policy that allows the APCD to provide detailed analytics at the individual level. Connecticut’s current policy prohibits using the APCD in this manner because of privacy concerns (State of Connecticut, 2013).

In the area of value-based payment, the Plan proposes that the executive branch seek a Medicaid waiver or SPA to broaden the scope of the PCMH program and align incentive payments with the payment and delivery system reforms (State of Connecticut, 2013).

Finally, to support implementation of workforce development, the Plan proposes legislation or regulation to expedite certification of community health workers, allow practitioners to practice at the top of their licenses, adopt loan forgiveness programs, include cultural competency standards for licensed providers, and develop training opportunities and career ladders (State of Connecticut, 2013).

8.3.3 Intended Impact of the Plan

The Plan sets forth four main goals for its transformation efforts: (1) improve health, (2) alleviate and eventually eliminate health disparities, (3) improve health care quality and care experience, and (4) reduce the rate of growth of health care spending per capita. The Plan notes

four implementation phases that will occur over 5 years. The first is a 9-month detailed design phase, during which more of the delivery system and payment model details, such as patient attribution to an AMH, would be developed. Second is a 9-month implementation planning phase, during which procurement for services to support Plan implementation would take place. Third is Wave 1 implementation. During this phase, most innovations described in the Plan would launch, including the multi-payer AMH model, and several workforce development initiatives (July 2015–June 2016). Finally, subsequent scale-up would occur through successive waves of implementation by June 30, 2020 (State of Connecticut, 2013).

As noted by some stakeholders and in the Plan, the Centers for Medicare & Medicaid Services (CMS) requirement that reforms reach at least 80 percent of the state’s population was a “guiding principle” for the state’s SIM Initiative efforts. The core team and stakeholders framed this tenet within the context of eliminating health disparities or achieving health equity, noted as the second main goal above but also “viewed not as a separate and distinct initiative, but rather inherent to all elements of the plan” (State of Connecticut, 2013). As shown in [Table 8-1](#) and discussed throughout this chapter, the state boasts several existing initiatives upon which the Plan expands that pursue similar goals.

The Plan notes specific populations to be targeted for each of its three main innovations: (1) AMHs would target all health care consumers in the state; (2) the Prevention Service Centers would target persons with diabetes, with asthma, or at-risk for falls; and (3) HECs would target vulnerable communities, including those with the greatest health disparities based on race, ethnicity, and socioeconomic status. Among populations with known health disparities, stakeholders noted that the Medicaid population has both the most to gain and the most to lose from the proposed model—that they would benefit to the extent their access to care, quality of care, and care experience improves, but with the potential that they would be “underserved” if the model gives providers a financial stake in lowering costs without appropriate checks or controls in place.

8.3.4 Proposed Next Steps

Connecticut has well-defined plans for implementing the Plan, with or without Round 2 Model Test funding. The state has begun to establish a governance structure that leverages the structure used for the design process. The Lieutenant Governor will provide overall leadership for implementation and will establish a Health Care Innovation Steering Committee—a successor to the existing Steering Committee—with additional consumer, consumer and health equity advocate, and provider representation. The state plans to establish a Project Management Office (PMO) with four or five full-time staff to lead detailed design and implementation, oversee evaluation efforts, engage with stakeholders, manage vendors, and communicate progress. The Lieutenant Governor has already designated a core team member to lead the PMO. The Steering Committee and PMO plan to seek ongoing input and guidance from

Connecticut's Health Care Cabinet and its recently reconstituted Consumer Advisory Board (CAB).

The state also proposes five specialized task forces and councils focusing on: (1) provider transformation standards, support, and technical assistance; (2) coordination of the various health IT projects; (3) quality, care experience, and health equity metrics and performance targets; (4) methods for safeguarding equity, access, and appropriate levels of service; and (5) workforce initiatives. Consumer membership in the task forces and councils will be facilitated through the CAB. The state plans to have most of this structure in place by February 2014.

8.4 Discussion

Connecticut began its planning process with a “shared vision of a broad range of stakeholders to establish primary care as the foundation of care delivery that is consumer and family centered, team based, evidence driven and coordinated, and in which value is rewarded over volume” (State of Connecticut, 2013). SIM Initiative leadership also respected the CMS mandate that reforms be designed to impact 80 percent of the state's population. From this vision and mandate, SIM Initiative leadership relatively quickly identified innovations in one main category—primary care practice transformation through an AMH model. Two additional categories of innovation received attention later in the process: community health improvement initiatives and consumer empowerment initiatives. The Plan reflects the substantial efforts the state and stakeholders undertook during the planning process. However, stakeholders expressed concern that the Plan does not adequately describe model components or how they would be implemented.

8.4.1 Critical Factors Shaping the Plan

As mentioned above, stakeholders noted the core team's vision for and commitment to the Plan development process. Initially, the core team envisioned the AMH model as the point of departure for primary care practice transformation, and earlier versions of the Plan included that model as the sole primary driver of innovation. As also discussed above, midway through the planning process, consumer advocates expressed concern that the draft Plan lacked adequate attention to quality of care and cautioned that shifting financial risk to providers might result in providers undertreating certain patients. Other stakeholders echoed similar concerns, although some stakeholders, especially state officials, felt that quality was always the foremost consideration and that these concerns reflected a misunderstanding of the draft Plan. Still, the final Plan more prominently incorporated community health improvement and consumer empowerment initiatives designed to address these concerns. Interviewees also considered it likely that changes to the future SIM governance structure resulted from consumer advocate feedback. For example, the final Plan incorporated or refined elements such as a Quality Metrics

Council, an Equity and Access Council, a CAB, and formal participation of consumer advocates and consumers on the Steering Committee (State of Connecticut, 2013).

8.4.2 Lessons Learned

Stakeholders identified several lessons learned during the Plan development process:

- **Developing a vision for change is easier than developing the Plan to pursue and implement that vision.** Most stakeholders noted that, although the state clearly has a vision for model redesign, the potential for implementation depends greatly on the specific details of the Plan. Multiple stakeholders used the same phrase to characterize this challenge: “The devil is in the details.” Their message was that particular components may or may not be feasible to implement and that stakeholder buy-in will depend greatly on the inclusion or exclusion of certain components.
- **Pursuing reform or innovation in the public sector presents unique challenges.** Connecticut’s SIM Initiative process involved stakeholders from both private and public sectors. Some private sector stakeholders and public stakeholders with prior private sector experience noted such challenges as the “slow pace” of “getting things done” in the public sector, the need to “[rub] elbows with the people that make decisions,” the mandate to solicit and incorporate feedback from many stakeholders, and the difficulties in “shepherding” various stakeholders who needed to be involved with design or implementation.
- **Input from stakeholders should be sought as soon as possible.** Some stakeholders, including state officials, expressed confidence that the stakeholder engagement strategy was appropriate and effective. However, consumer advocates criticized the state’s strategy to engage them and reacted negatively to specific proposed elements of the plan. Stakeholders noted the challenge of balancing a potentially more nimble design process—one with smaller, tighter decision-making groups—with a process that might require redirection midstream because of lack of buy-in across all stakeholders.
- **Stakeholders should be kept apprised of the process and Plan elements.** Several stakeholders noted challenges with “publicizing” or informing stakeholders throughout the state of SIM Initiative efforts. As one stakeholder put it, “there’s no such thing as over-communication. I would spread the word a lot like voting in Chicago: early and often.” Some stakeholders, such as physicians and payers, noted that their stakeholder group peers and the public at large were unaware that Connecticut received the planning grant and knew little of the Plan’s details. Without fully knowing and understanding the Plan’s elements, some stakeholders “assume[d] the worst.”
- **Efforts to pursue system-level reform require being a team player.** Stakeholders identified the need to “get out of your sandbox” and realize that “we’re all here for the same reason.” On the whole, stakeholders involved in the Connecticut design

process appeared to have had a collegial or, at least, neutral and productive relationship. But tensions were said to arise when stakeholders focused too narrowly on their own agendas and did not “think more broadly” in terms of the greater value in reform efforts.

8.4.3 Potential for Implementation

Stakeholders perceived a lack of details as one of the main threats to successful implementation of the Plan. For example, one stakeholder noted that he has “seen no teeth in [the] Plan,” (i.e., few details regarding funding and the timeline for implementation). Some stakeholders acknowledged that the relatively short timeframe for Plan design, and the major scope of system-level reform, rendered it impossible for the core team and Steering Committee to “get down to the granular level.” Stakeholders also expressed concern regarding sufficient buy-in and even basic understanding of the Plan’s elements throughout stakeholder groups, which would be needed for successful implementation. However, most stakeholders agreed that reform was necessary and that “there is enough support and interest to make something happen.” Finally, interviewees said that existing strategies, initiatives, and priorities might facilitate or hinder implementation of the Plan. For example, on the one hand, payers noted that they are already “focusing on value,” a key principle underlying Connecticut’s SIM Model. Many providers already have experience with PCMHs, the foundation for the Plan’s AMH model. On the other hand, in the past consumers and other stakeholders, including providers, have resisted and may continue to resist managed care–like ideas and initiatives, several of which are included in the Plan as it aims to shift from purely FFS payment to incorporating value-based payment approaches.

8.4.4 Applicability to Other States

The state contracted with a national consulting firm that brought extensive knowledge of and data on other states’ health care initiatives and environments. The core team and other stakeholders adamantly asserted that Connecticut’s model “is a completely different model than what other states are doing.” From the outset, the core team sought to include elements that would make their Plan distinctive, such as a readiness to launch with extensive stakeholder support, promotion of health equity, an Equity and Access Council, Prevention Service Centers and HECs, and a Connecticut Service Track for Healthcare Workforce Development (State of Connecticut, 2013). Thus, Connecticut’s model *in its totality* may be unique, though individual components or strategies may be applicable to other states.

8.4.5 Limitations of This Evaluation

We wrote the case study with information gleaned from interviews of several people within each major stakeholder group, with one exception. We were only able to speak to one insurer representative, whose views were self-described as not necessarily representing those of other insurers. In addition, some stakeholders said they had “checked in” with the core team

before speaking to us and were speaking as representatives of the SIM Initiative. As such, our interview data may suffer from response bias; respondents may have told us what they thought we wanted to hear. Because we conducted stakeholder interviews before the state submitted its final Plan, the stakeholder comments reported here may not accurately reflect opinions of the final Plan.

8.5 References

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Appendix Table 8A-1. Models and strategies proposed in Connecticut Health Care Innovation Plan

| Model type or strategy | Preexisting model, program, or initiative that Plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|---|--|--|--|--|
| <p>AMH Model</p> <p>Promote whole person–centered care by using simple assessment tools to understand the holistic needs of patients and coordinate care to meet these needs</p> <p>Enhance access by removing barriers to participation in health care</p> <p>Use population-based data to identify at-risk populations and develop interventions to reduce health equity gaps</p> <p>Implement multidisciplinary teams across medical care and behavioral health care</p> <p>Use evidence on clinical outcomes and cost-effectiveness to inform clinical decisions</p> | <p>Medicaid PCMH</p> <p>Program based on the Joint Commission and NCQA medical home models</p> <p>Existing medical home initiatives focused on advanced primary care</p> | <p>General population (multi-payer launch aimed for July 2015–June 2016)</p> | <p>Proposed executive branch or voluntary actions</p> <ul style="list-style-type: none"> * Establish entity to define practice standards for provider entry to and participation in the model * Medicaid waiver or SPA to broaden the scope of PCMH program and align incentives with the payment and delivery system reforms <p>Establish online licensure application and renewal processes to encourage provider participation in AMH (to be determined)</p> <p>Payment policies or union discussion to enable Medicaid and state employee participation in the model (to be determined)</p> <p>Proposed state regulatory action</p> <ul style="list-style-type: none"> Regulation to allow adult behavioral health clinics to co-locate licensed clinicians in primary care practice settings Insurance regulation or carrier policies to remove barriers to primary care-behavioral health integration (to be determined) Regulations to remove barriers to participation in AMH and the shared savings program (to be determined) | <p>Providers and payers</p> |

(continued)

Appendix Table 8A-1. Models and strategies proposed in Connecticut Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that Plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|--|---|---|---|--|
| <p>Infrastructure to support delivery system transformation Implement designated Prevention Service Centers including new or existing community-based organizations, providers, or local health departments that provide evidence-informed prevention services and link to primary care providers</p> | <p>Existing community prevention programs: (1) Diabetes Prevention Program, (2) Asthma Home Environment Assessment Programs, and (3) Falls Prevention Program</p> | <p>Consumers with diabetes, with asthma, or at risk for falls</p> | <p>Proposed state legislative or regulatory actions * Legislation <i>or</i> regulation to designate and provide resources for Prevention Service Centers (to be determined)</p> | <p>New or existing local organizations, providers (e.g., FQHCs), nonprofits, or local health departments</p> |
| <p>Public health strategies Establish HECs to coordinate resources and promote partnerships to improve community health and reduce health disparities</p> | <p>Existing CDC-initiatives: (1) Community Transformation Grant ; (2) Racial and Ethnic Approaches to Community Health; and (3) Action Communities for Health, Innovation, and Environmental Change</p> | <p>Priority focus on vulnerable communities, including those with the greatest health disparities based on race, ethnicity, and socioeconomic status (three to five pilot communities in place by 2018)</p> | <p>Proposed state legislative or regulatory actions * Legislation <i>or</i> regulation to designate and provide resources for HECs (to be determined) Legislation <i>or</i> regulation to continue to address exposure to secondhand smoke in indoor environments, reduction of the availability of tobacco products, reduction of the consumption of excess sodium, increased access to affordable and nutritious foods and beverages, increased access and opportunities for physical activity, increased access to programs that prevent dental caries/cavities, and increased use of credentialing and certification of CDSM programs and providers (to be determined) Proposed state executive branch action Department of Public Health to support each HEC with epidemiologic and data</p> | <p>Providers, hospitals, local health departments, health centers, other public health experts, and community groups</p> |

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Appendix Table 8A-1. Models and strategies proposed in Connecticut Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that Plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|--|--|-----------------------|--|--|
| Consumer empowerment initiatives Provide information to consumers and encourage them to engage in shared decision making with providers Appoint consumer to roles in the SIM governance structure and ask them to complete consumer experience surveys so they can provide input Incentivize consumers for positive health behaviors by promoting VBID and employer incentive programs that reward purchasing food with high nutritional quality | Existing consumer engagement initiatives, including (1) the Center for Medicare & Medicaid Innovation–funded Incentives for the Prevention of Chronic Disease in Medicaid Demonstration; and (2) the Choices program, culturally competent nutrition education courses Existing VBID program: Several major self-insured employers and the Health Enhancement Program for the Connecticut state employees health plan | General population | Proposed state regulatory action * Legislation <i>or</i> regulation that facilitates consumer access to the APCD (to be determined) Proposed executive branch action Office of state Comptroller to convene a task force to recommend VBID options for insurers and employers | Consumers, employers, payers, providers, and the state |
| Performance transparency Create a common scorecard for AMH providers to measure health status, quality of care, and consumer experience | Connecticut Data Collaborative makes health care data publicly available in a central portal | General population | Existing state legislation * Public Act 12-166 supported the development of an APCD to receive protected health information from carriers, including public payer data such as Medicaid and Medicare | Consumers, payers, policy makers, providers, and practices |

(continued)

Appendix Table 8A-1. Models and strategies proposed in Connecticut Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that Plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|--|---|-----------------------|--|--|
| Track primary care performance for quality, care experience, equity, and cost measures | Department of Mental Health and Addiction Services provides a Web-based data information system—the DMHAS Data Performance system Department of Social Services’ “My Place” Web site provides shared decision-making tools, information on accessing community health services, and a clearinghouse for caregivers | | Proposed state legislative or regulatory action * Legislation that supports transparency in health care price information for consumers and requires notice of acquisition of physician provider practices (to be determined) * Legislation or regulation that facilitates consumer access to the APCD(to be determined) * Legislation or regulation to ensure payer reporting on public health and quality metrics used in the model (to be determined) | |
| Combine data across payers to analyze provider performance across patient panels | | | | |
| Design reports to disseminate information to consumers, payers, providers, and policy makers | | | | |
| Value-based payment | Medicaid and commercial payer implementation of value-based payment initiatives that emphasize ACO and PCMH models; commercial payer implementation of P4P and ACO initiatives | General population | Proposed state executive branch action * Medicaid waiver or SPA to broaden the scope of the PCMH program and align incentive payments with the payment and delivery system reforms (to be determined) Payment policies or union discussion to enable Medicaid and state employee participation in the model (to be determined) Apply for and win Round 2 Model Test award to dedicate staff to employer engagement | Payers, providers, and employers |
| Increase proportion of value-based payment | Participation of six Connecticut organizations in the Medicaid SSP ACOs | | | |
| Align all payers to adopt a value-based payment for AMH, either (1) P4P; or (2) a SSP (for AMHs with sufficient patient panel size) with at least upside-only risk, and, for payers other than Medicaid, potentially upside or both upside and downside risk | | | | |

(continued)

Appendix Table 8A-1. Models and strategies proposed in Connecticut Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that Plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|---|--|-----------------------|---|--|
| Encourage payers to tie P4P and SSP to one common scorecard for quality, care experience, health equity, and cost Establish an Equity and Access Council to recommend methods that could detect and prevent underservice by providers under a value-based purchasing model | | | Proposed state legislative or regulatory action Regulations to remove barriers to participation in AMH and the shared savings program (to be determined) Potential state executive branch action Co-fund a vendor to assess care experience of patients within an AMH, regardless of payer State facilitation of system change Payers adopt value-based payment options, but each sets their own pricing and risk levels | |
| Health IT Support advanced payer and provider analytics Create a multi-payer portal for providers and consumers Provide guidelines for care management tools Standardize its approach to clinical information exchange | Connecticut Data Collaborative’s central portal for publicly available health care data Department of Mental Health and Addiction Services’ Web-based data information system called the DMHAS Data Performance system Access Health CT, the state’s health insurance marketplace that helps uninsured individuals obtain health care coverage | General population | Existing state legislation * Public Act 12-166 supported the development of an APCD to receive protected health information from carriers, including public payer data such as Medicaid and Medicare Proposed state legislative or regulatory action * Legislation or regulation that facilitates consumer access to the APCD (to be determined) * Policy that allows the APCD to provide detailed analytics at the individual level Requirement for electronic medical records to meet technical standards that ensure their ability to work together | State, payers, and providers |

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Appendix Table 8A-1. Models and strategies proposed in Connecticut Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that Plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|--|--|--|---|---|
| | HITE-CT, the state’s tool to share health information across doctors, hospitals, and other providers | | Requirement for clinical labs to electronically report data to the ordering physician and the APCD using consistent codes and values Regulation that enables solo and small practices to share clinician and cost information with their peers and across practices | |
| Workforce development | | | Proposed state legislative or regulatory action | |
| Collect health workforce data and analytics | University of Connecticut’s data collection efforts on student education and projected workforce participation | General population (Launch July 2015– June 2016) | * Legislation <i>or</i> regulation to expedite certification of community health workers, allow practitioners to practice at the top of their licenses, adopt loan forgiveness programs, include cultural competency standards for licensed providers, and develop training opportunities and career ladders (to be determined) | State, providers, health professional associations, the University of Connecticut, Yale University, Quinnipiac University, other Connecticut state colleges and universities, the Connecticut Institute for Primary Care Innovation , and Connecticut’s Area Health Education Centers |
| Create a Connecticut Service Track (community-based interprofessional education program) | University of Connecticut’s Urban Service Track as foundation for Connecticut Service Track | | State facilitation of system change | |
| Develop training and certification standards for community health workers | | | Clinical schools develop learning collaborative dedicated to interprofessional education that would support interprofessional primary care | |
| Prepare providers to adapt to advanced and accountable care delivery models | Council for State Boards of Nursing stores and analyzes data for Connecticut nurses | | Area Health Education Center network develops training for community health workers | |
| Revise primary care graduate medical education and residency programs to better align with health care reforms | | | Learning collaborative to improve primary care residency programs | |

(continued)

Appendix Table 8A-1. Models and strategies proposed in Connecticut Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that Plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|--|---|-----------------------|--|--|
| Improve science, technology, engineering, math preparation of future health and allied health professional workforce, and improve ability to apply training to different positions to respond to workforce demands | | | | |

¹Policy levers are defined as one or a combination of the following: Medicaid waiver; federal grants (including Round 2 SIM award); state law; state regulation; state investment (e.g., in public health programming); foundation grants; employer-led coalition to drive change among providers, purchasers, or plans; state government-led coalition, task force, or commission to drive voluntary change among providers, purchasers, or plans; state purchasing contract; state-level (Governor-initiated) executive policy directive; or other (describe).

Abbreviations: ACO = Accountable Care Organization, AMH = Advanced Medical Home, APCD = all-payer claims database, CDSM = Chronic Disease Self-Management, DMHAS = Department of Mental Health and Addiction Services, FQHC = federally qualified health centers, HEC = Health Enhancement Communities, HITE-CT = Health Information Technology Exchange of Connecticut, NCQA = National Committee for Quality Assurance, P4P = Pay for Performance, PCMH = patient-centered medical home, SIM = State Innovation Model, SPA = state plan amendment, SSP = Shared Savings Program, VBID = value-based insurance design.

9. Delaware

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Delaware is a very small state with a health care system characterized by small independent providers in a largely fee-for-service system and relatively limited resources going to public health in the state. At the same time, it is a leader in health information technology (health IT), with virtually all its providers and all its hospitals included in its Health Information Network. Strong consensus in the state that Delaware needed to reform its health care system to be more in line with health care transformation trends elsewhere was a major influence on development of its Health Care Innovation Plan (the Plan).

To develop the Plan, Delaware created a leadership team and six work groups comprising state agency and private sector stakeholders convened by the Delaware Health Care Commission and supported by its contractor, McKinsey & Company. The planning effort had the full and active support of the Governor, and the state made significant efforts to include a broad base of stakeholders through work groups and public stakeholder meetings.

The Plan proposes a delivery system and payment model that allows for flexibility in the type of provider organizations that can participate. The goal of the Plan is to transition most Delaware providers to an outcomes-based payment system using total cost of care and pay-for-value arrangements, which may include hospital or nonhospital-based Accountable Care Organizations (ACOs), or other organizations formed by independent physician practices. The Medicaid program's aspiration is that new payment models would be available in mid-2015 and commercial payers would follow with similar models in ensuing years. The Plan emphasizes voluntary effort, supported by executive and legislative change. To help with implementation of the Plan's core elements, the state also plans to create a new state entity, the Delaware Center for Health Innovation—a 9- to 15-member board of patient, provider, payer, employer, and state agency representatives. Initial Center work would focus on designing payment models and infrastructure support. The Plan estimates achieving at least 8 percent net savings over 10 years. Most of the population is projected to be covered through nearly universal provider participation in the new payment models.

9.1 Context for Health Care Innovation

With a population of under one million, Delaware is a small state both in population and geography; its health care landscape consists of seven major health systems—the largest identified as Christiana Care Health System—with two payers dominating the commercial insurance market (Highmark Blue Cross Blue Shield and Aetna). The state provides coverage to

nearly 37 percent of the population, either through Medicaid (25 percent) or state employee benefits (12 percent) (State of Delaware, December 2013). Delaware has a mix of ongoing private sector, state-led, and federally sponsored initiatives focused on improving health and the health care system—including the Delaware Patient-Centered Medical Home Initiative pilot; Christiana Care Medical Home Without Walls Project; A.I. duPont Hospital for Children’s patient-centered medical home model for children with asthma; Christiana Care’s Bridging the Divide Innovation Award to use a clinically integrated data platform to support care management programming for the ischemic heart disease population; and the Beebe Medical Center CAREs initiative to empower complex chronic patients through care coordination, access, and advocacy. Despite these initiatives, the state ranks 31st in *America’s Health* rankings of states (United Health Foundation, 2013), reports higher than average health care spending per capita (SHADAC, 2012), and is dominated by a fragmented, fee-for-service delivery system. Limited resources are currently dedicated to community, public health, or social services—making it difficult to improve health outcomes, particularly in the area of medical and behavioral comorbidities, which represents nearly 50 percent of all health spending in the state.

A shortage of primary care providers (PCPs), dentists, and mental health care providers exists, primarily in rural areas of the state. The state also has vast variation in the level of engagement of the nonphysician workforce, with nearly half of primary care practices reporting no care team members aside from the PCP—a result of a preponderance of small independent practices scattered throughout the state (more than 75 percent of Delaware’s providers work in small practices with five or fewer physicians). To overcome some of these workforce shortages, Delaware has several programs in place, including multidisciplinary training programs through the Delaware Health Science Alliance, a partnership of several major health care systems and universities both within and outside Delaware; integrated team-based approaches for physicians in training at the University of Delaware; and the Delaware Health Care Commission’s State Loan Repayment Program. The latter has expanded access to care for 25,000 Delaware residents by creating a 400 percent increase in primary care, mental health, and dental provider recruitment.

Delaware is a national leader in health IT. The state led successful implementation of the nation’s first statewide health information exchange (HIE) (the Delaware Health Information Network). Currently, 98 percent of providers and 100 percent of hospitals use the Health Information Network, rendering the Network an important tool in Delaware’s current health care infrastructure, through which it intends to expand data-sharing capabilities in the future.

9.2 Planning Infrastructure and Process

Governor Jack Markell delegated oversight of the Model Design process to the Delaware Health Care Commission, a public-private policy-setting body with responsibility for several

health care–related programs and initiatives and functioning as the primary health policy forum in the state. Guided by its contractor, McKinsey, the Commission developed a multi-stakeholder, multi–work group process to cultivate ideas for the Plan. Stakeholders reported that the leadership team for this process made every effort to ensure an open and transparent communication process during the summer and early fall 2013.

Governance and management. This process had the Governor’s attention, commitment, and interest, according to stakeholders, which they believed galvanized stakeholders and sent the message that any stakeholder invested in the future of Delaware’s delivery system needed to be part of the Plan’s development. People realized quickly that something meaningful was happening. Interviewees described the Governor as a hands-on leader of the initiative, having convened key stakeholders (e.g., the medical society, hospital association, nursing associations, and major payers) at the beginning of the effort, lending his support to the process, and making sure everyone knew this was his priority.

The chair of the Delaware Health Care Commission and the health policy advisor to the Governor led the work throughout the planning process, with active participation of the state Health and Social Services Secretary. This high level of engagement made it clear that this was an important initiative. The leadership team also included the Directors of Public Health, Medicaid, and Division of Professional Regulation; elected officials, including the chairs of two health committees in the general assembly; and the dean of the University of Delaware College of Health Sciences and the insurance commissioner, both of whom are also members of Delaware’s Health Care Commission. The leadership team made a concerted effort to connect the work of the Model Design process to Patient Protection and Affordable Care Act (ACA) activities, such as HIE development and Medicaid expansion.

Delaware contracted a consultant team through McKinsey that was heavily involved and instrumental in shaping and facilitating both the overall Plan development process and models proposed by the Plan. McKinsey provided both subject matter expertise from experiences in other states and research to work group meetings, plus administrative support in the form of scheduling and logistics. Stakeholders felt McKinsey did a good job developing structure and pushing work group members to move forward to address critical issues.

Work groups. The leadership team identified leaders from the public and private sector to facilitate each of six work groups (delivery models, payment models, data and analytics, population health, workforce development, and policy). After a statewide solicitation for input during the design grant development process, work group membership consisted of self-identified stakeholders with expertise and interest in shaping the Plan. The work group meetings, which took place from mid-May through August, were open to the public and publicly announced via the Health Care Commission’s Web site. The leadership team offered video conferencing in two locations, in-person attendance, and a call-in option so people statewide

could participate. Work group meeting announcements were sent to people who had requested to be on the mailing list for that work group. Typically, 20–30 high-level decision makers attended meetings.

During meetings, work group leaders posed two to three key questions to attendees for input. McKinsey’s consultant team processed comments on the key questions, synthesizing major issues for the leadership team and work group leaders. The process used to solicit input during work group meetings included democratic polling. Items with the greatest response were presented to the group to show stakeholder priorities. The leadership team then narrowed down options based on majority opinion.

Work group meetings were staggered to build on one another’s progress. For instance, the payment work group started a few weeks before the data and analytics work group to provide information on the kind of health IT infrastructure needed to support the Plan. Policy was the last work group to meet, so that once the design was fleshed out, members could consider needed policy change (e.g., legislative or regulatory action). To facilitate cross-work group learning, the state hosted four 3- to 7-hour cross-work group sessions for stakeholders (attendance ranged from 75 to 125 individuals) to engage in an interactive discussion on the work happening across all work groups. During these meetings, people had the opportunity to electronically vote from their seats on what they thought of the draft Plan. Work group leaders also met regularly to ensure integration of their efforts.

Stakeholder engagement. After an early May kickoff day of public comment and public awareness to encourage very broad multi-stakeholder engagement, program leaders facilitated four public stakeholder meetings between May and September with support from McKinsey, and participation of up to 100 people at each. Public stakeholder meetings included presentations from the work groups along with working exercises with issues posted around the room, so that people could vote for their highest priorities. The tone and tenor of every public stakeholder meeting was described thus: “Let’s work together for Delaware. If you see problems we’re not recognizing, speak up so that we can figure out how to address it as part of the Plan because this is going to be our Plan collectively.” Once a draft Plan was formulated, the leadership emailed it to stakeholders and presented it at three public stakeholder meetings held in September. The leadership team assimilated all input received on Plan drafts into subsequent drafts, resulting in a Plan that evolved over time based on stakeholder input.

The Health Care Commission was also instrumental in involving stakeholders. Its work over the last couple of years around ACA implementation solidified its role as the convener of the Model Design process. After the State Innovation Model (SIM) Initiative funds were awarded, participation in the Commission’s regular monthly meetings increased from 50 to 60 people per meeting to more than 100. The Commission’s network, including hundreds of people on an email distribution list, was used to keep people informed, along with a specific distribution

list created for the Initiative. A portion of each of the Commission’s meetings was devoted to an update and opportunity for input on the Plan.

Stakeholders described extraordinary efforts to make the Plan development process open, transparent, inclusive, and proactive. As one of them put it, “Delaware is small. Relationships matter. Those have all been honored.” The Governor was described as expecting the leadership team to secure extensive stakeholder involvement, and the leadership team agreed early on to use a stakeholder engagement structure rooted in community-based engagement.

Stakeholders noted great momentum and appreciation for being at the table through the Model Design process and for providing input into any kind of broad-stroke plan or transformation the state decided to move forward. Despite concerns from some stakeholders, one expressed appreciation for the state’s efforts to “make [stakeholders] feel as though they would not be lost in the process [and that they would] be given time to prepare and adjust to any major changes” to come out of the Plan. Stakeholders also noted that the process overall seemed inclusive of most important stakeholders in the state, including top senior-level decision makers from across all sectors of the health care system (e.g., payers, providers, advocates), with the exception of mixed feedback on the inclusion of large self-insured employers and on the adequate engagement of consumers and patients. Some emphasized a need to coordinate with, and engage, payers in the implementation phase because many are already implementing their own payment and delivery reform and the Initiative is a significant opportunity for the state to unify these reforms. One expressed concerns about lack of involvement of community-based organizations, non-physician providers, and community health workers; others mentioned lack of representation for people with disabilities, the homeless, farm workers, older populations, and the long-term care system.

Resources and infrastructure. Delaware used the SIM award funds to support the contract with McKinsey and state resources (e.g., staffing) to support the Model Design process. The state did not provide any additional direct funding, but the Delaware Cancer Consortium did provide \$50,000 in state funds to enhance an existing all-payer claims database (APCD), which will support enhanced statewide data analytics and reporting proposed by the Plan while simultaneously supporting a claims-based cancer registry. Members of the leadership team provided in-kind support in the form of meeting rooms and extensive staff support for the Model Design process.

9.3 The Delaware Plan

Delaware’s Health Care Innovation Plan proposes statewide transition to outcomes-based payment models for care, with flexibility in the type of provider organizations that can participate. ACOs or other independent provider organizations serve as potential models. The ultimate goal is for nearly all Delawareans to receive care from providers whose incentives are

linked to outcomes. According to the Plan, “The transition paths [to this new model] will vary to account for differences in starting point experience with taking accountability for quality and cost outcomes” (State of Delaware, December 2013). As part of the Plan, payers would fund practice investment in care coordination. Delaware’s delivery system transformation focuses on care coordination for high-risk individuals, who represent 5 to 15 percent of the population, with an emphasis on integration of behavioral health services and medical care. Delaware would also focus on more effective diagnosis and treatment to reduce unwarranted variation in care for all population segments. Delaware would complement the care delivery and payment model innovations with community-based approaches to robust integrated care and a strong health information network. Delaware is considering policy levers and tools to enable health care transformation, including information aggregation, purchasing, regulation, and legislation—particularly in the areas of licensing and credentialing providers, payment innovation, data and analytics enhancements, and governance.

9.3.1 Models and Strategies

The Plan proposes innovations in six main categories: (1) statewide transition to outcomes-based payment models, (2) infrastructure to improve population health, (3) workforce development, (4) delivery system infrastructure and support, (5) health IT and enhanced data analysis, and (6) patient engagement. All innovations considered during the Plan development process fell into these main categories. [Appendix Table 9A-1](#) provides a summary description of the innovations, initiatives on which they are built, populations they address, policy levers proposed, and implementation entities.

Statewide transition to outcomes-based payment models. Delaware proposes to transition to outcomes-based payment models through new requirements in Medicaid with anticipated voluntary participation from commercial payers. Medicaid would offer providers two models: (1) a pay-for-value model where providers earn bonuses for both meeting a set of quality measures and managing resource utilization, and (2) a total-cost-of-care model where providers share in savings generated by the system if they both meet a set of quality measures and reduce health care costs per member for their patients compared against a benchmark. Delaware will require its Medicaid managed care organizations to offer payment models consistent with these two options when the new contract period begins in 2015. Delaware will invite Medicare to offer similarly structured models. Commercial payers may also consider these models for their outcomes-based payment models. To participate in the new payment system, providers will have flexibility in how they organize (e.g., ACOs or groups of independent providers). With the intent to maximize participation (especially from behavioral health and primary care providers), requirements will allow flexibility for design of structures and minimum panel requirements.

Infrastructure to improve population health. The Plan would invest in activities to ensure seamless integration and coordination of the delivery system model with the broader

community and with non–health care providers and organizations. The Plan calls for complementing the care delivery and payment innovations with a “Healthy Neighborhoods” model, which integrates communities with their local care delivery systems and better connects community resources with one another. Integration will be achieved through dedicated staff and neighborhood councils of community organizations, employers, and providers—including care coordinators and community health workers, who will lead care coordination in the community and across clinical settings. It is further anticipated that Healthy Neighborhoods would be supported through in-kind contributions from multiprofessional health care facilities. To effectively target and serve patient populations, each healthy neighborhood would be responsible for maintaining a tailored database of resources based on the health needs and social makeup of its members. Prospective Healthy Neighborhoods from across all geographic areas in the state are to submit applications to the Delaware Center for Health Innovation (described below). Details on the criteria for selection will be developed at a future date.

Workforce development. To support better care coordination and the Healthy Neighborhoods model, Delaware has significant needs for additional care coordinators who can practice in multidisciplinary care teams and a broader health care informatics and health IT workforce. The Plan includes strategies to improve the capacity of providers (e.g., nurse practitioners) to practice at the top of their license and improve training for those capable of serving as care coordinators (e.g., health coaches, nurse navigators, and community ambassadors). The workforce-specific strategies included in the Plan focus on such issues as aligning definitions and roles of health care professionals (e.g., care coordinators), assessing opportunities to retrain people from non–health care sectors, multidisciplinary team training, extending graduate medical education in underserved areas, developing top-of-license guidelines, and establishing a multi-stakeholder health professions consortium to monitor workforce development.

Delivery system infrastructure and support. After examination of data on current health care spending in the state, the state identified two major cost drivers: patients with chronic conditions and large variation in diagnosis and treatment of illness leading to large disparities in costs. Accordingly, the Plan proposes several strategies to enable more coordinated delivery and more effective diagnosis and treatment across the state. Tools available to providers would include development of a common set of quality measures and a set of shared services and resources for providers. Four non-technology shared services are to include a forum to refine/develop clinical guidelines and protocols targeting high-risk and high-cost conditions, support for practice transformation, fostering learning collaboratives for providers transitioning to new care delivery models, and support for access to care coordinators and care coordination tools and resources.

Health IT and enhanced data analysis. Given Delaware’s advanced status with respect to HIE and health IT adoption, the Plan focuses on opportunities to improve infrastructure and effective use of health IT to support new payment models. The state proposes to develop data and analytic capacity to evaluate and report on provider performance (e.g., total cost of care calculation, care gap analysis, performance reporting) to support new payment and delivery models. In addition, Delaware aspires to build care gaps and risk stratification tools as shared services to enable providers to deliver more coordinated care. The Plan describes a long-term vision that includes payer claims-based tools to implement the payment model—specifically, a risk stratification tool to identify patients in the top 5 to 15 percent of need for care coordination and to foster communication about care needed among providers, patients, and their families. Through the tool, providers would receive an integrated summary of their patient panel, across all payers, that would include patient risk scores for care coordination support, total cost of care, care gaps, conditions, and a variety of other related data. Health IT investments would include establishment of a set of patient population management tools—such as care coordinator workflow capabilities, member engagement functionality (e.g., email, mobile), and sophisticated clinical database analytics that can be transmitted to all practices in real time. Integration of ambulatory data would be accelerated to equip providers with a full longitudinal patient record for their patients. In addition to analytic tools, the state proposes to create a Web-based, multi-payer portal to enable the exchange of information between payers and providers. Providers would also be able to use the portal to submit quality metrics via their electronic health record and the HIE.

Patient engagement. Delaware proposes to launch a statewide patient engagement plan, including implementation of a statewide social marketing and education campaign, to communicate unified health and health care decision making and utilization messages to empower patients to be fully engaged participants in team-based care. The engagement strategy is also to include development of a series of innovative publicly downloadable apps to address personal health empowerment (e.g., through promotion of chronic disease self-management and risk-reduction behaviors) and improved transparency about Delaware's health care system. Through the apps, patients will gain easy electronic access to their personal medical records and information to enable value-conscious health care choices. Finally, the state has proposed to develop a Web-based portal for patients to access their health information and to evaluate and select the providers that best meet their individual needs.

9.3.2 Policy Levers

Existing and proposed policy levers for Plan implementation are listed in [Appendix Table 9A-1](#). The state’s primary emphasis is on voluntary participation, supported by regulatory and executive branch action to catalyze changes proposed in the Plan, although several of the proposed Plan elements did not have clearly identified or defined policy levers to enable implementation. Although the state lists several entities that would be involved in the Plan’s

implementation, the primary state agency enablers are to be the Department of Health and Social Services, the Health Care Commission, and the Delaware Health Information Network. Together with public and private stakeholders, the state would also create a new governance entity, the Delaware Center for Health Innovation, to guide and implement core Plan elements.

The Department of Health and Social Services would begin movement toward outcomes-based payments in the state through requirements added to Medicaid Managed Care procurements as early as January 2014, with contracts reflecting new payment models to be in place in 2015.

The Health Care Commission would work collaboratively with the deputy attorney general to implement state policies necessary to support voluntary commercial payer participation and multi-payer alignment across new payment models. The Health Care Commission has already convened a work group of public/private stakeholders to address provider workforce shortages.

Policy or regulatory action would be required to finance and enforce the Delaware Health Information Network's enhanced role supporting robust health data infrastructure throughout the state—including a new provider portal, APCD, and data management services for payers and providers. Delaware Health Information Network's board and legislative staff are to work to develop appropriate actions in the upcoming year.

9.3.3 Intended Impact of the Plan

Delaware developed a projection of the Plan's impact that estimates an 8 percent or greater net savings in health care costs over 10 years. This projection assumes a 90 percent provider participation rate in total cost of care payment models and a 5 percent provider participation rate in pay-for-value models. Delaware assumes that most of the state's population will be affected by the Plan through nearly universal provider participation in these new models.

Although full details of the Plan were not available at the time of our interviews, some stakeholders did express positive opinions regarding the Plan's likelihood of reaching a majority of the population. Several interviewees raised the significance of the Plan's multidimensional approach, focused largely on improvement in care coordination, as critical to achieving health improvements—not only for special and complex needs patients, but also for the population as a whole. As stated by one interviewee, “[the Plan is] identifying, in one vehicle, where are the gaps [in the health system] and the solutions to fill those gaps.”

9.3.4 Proposed Next Steps

Delaware has proposed several concrete steps beginning in early 2014 to move forward with its Plan, including revisions to its Medicaid Managed Care procurements and establishment

of the Delaware Center for Health Innovation. Most interviewees emphasized the need for a governance structure like the proposed Delaware Center for Health Innovation to enable continued progress on the Plan. While details about the exact structure of the Center were still in development at the time of our interviews, many stakeholders endorsed a public/private model—used successfully by both the Health Care Commission and the Delaware Health Information Network. As one interviewee put it, “[The governance structure] needs to have one foot on both [public and private] sides to pull [the Plan] together,” that is, a structure without undue influence of either government agencies or private sector partners. The responsibilities of the Delaware Center for Health Innovation would include the following:

- developing a common scorecard to track the progress of providers across cost and quality performance and outcomes measures;
- promulgating public transparency of scorecard results;
- setting up shared services and resources to support the transition to coordinated care, including clinical protocols and guidelines to support effective diagnosis and treatment;
- cultivating and managing a technology-enabled patient engagement strategy to give patients better access to information and resources necessary to improve their health (e.g., disease management tools, information about local health services);
- improving workforce education and training to support providers and transform Delaware into a “learning state”; and
- creating and implementing the Healthy Neighborhoods program.

The Center is to be composed of a multi-stakeholder, 9- to 15-member board inclusive of patient, provider, payer, employer, and state agency representatives; a full-time staff of an Executive Director and two administrators; and the four committees described earlier. The Center would be required to report twice yearly to the Governor, general assembly, Health Care Commission, and Delaware Health Information Network on progress toward implementing Plan elements. Early activities of the Center would include detailed design of payment models and infrastructure support (e.g., scorecards, identification of data needed for provider reports) needed to implement the Plan.

During early 2014, Delaware plans to focus on development and submission of a Model Test proposal. Meanwhile, the state plans to engage the Centers for Medicare & Medicaid Services (CMS) in how to best align Medicaid and Medicare payment models with those proposed in the Plan.

9.4 Discussion

Throughout the development process, Delaware garnered widespread support for its proposed Plan, leveraging high-level state leadership and relationships built across both private and public stakeholders. Although there remain concerns over details, or lack thereof, included in drafts of the Plan (particularly in the areas of governance and funding of innovations), agreement exists that this opportunity has been a first step in moving Delaware and its key health care constituencies toward shared goals of improving Delaware’s health care system.

9.4.1 Critical Factors Shaping the Plan

The influence of stakeholders and support from McKinsey played an important role in Plan development. Broad stakeholder agreement that the state’s health care system needed to change enabled the state to develop a Plan that, although sparse on many implementation details, has garnered widespread support among stakeholders. The Plan seeks to incorporate delivery transformation models implemented in other states, while also building on current infrastructure within the state. The Plan was ultimately influenced by pragmatic needs, according to stakeholders, including assumptions about CMS requirements for future Model Test funding opportunities.

Many stakeholders recognized that the health care system in Delaware has fallen behind, and voiced collective consensus that change to Delaware’s delivery systems would be not only beneficial, but necessary to keep up with a national movement toward health care system transformation. Stakeholders were readily engaged, even without critical details regarding Plan implementation. One stakeholder described this as analogous to the state getting everyone in the boat, pushing off, and then choosing a direction—that regardless of the direction the Plan would take, “we’re in the boat, so there’s no going back.” However, stakeholders were satisfied with the likely direction, endorsing Delaware’s strategy to primarily rely on voluntary payer participation in system reforms rather than excessive legislative or regulatory mandates.

Stakeholders were mixed on how well the Plan draws on successful examples of health system transformation in other states while also building on current Delaware initiatives and infrastructure. For example, several interviewees noted significant opportunities for the state to explore best practices in other states, yet full exploration of options was limited by lack of time and resources. Some pointed to various examples of how those developing the Plan were mindful of leveraging infrastructure already in place, particularly the Delaware Health Information Network, although many questions were left outstanding as to how the Delaware Health Information Network can best be enhanced to meet the goals of the SIM Initiative while also allowing flexibility for providers or others who wish to use their own tools.

As the leadership team refined the models in its final Plan, many of the final decisions were ultimately made to meet CMS guidelines or assumed expectations. For example, despite suggestions for stakeholders to include models that would ensure long-term sustainability, models included in the Plan tend toward short-term proposals that can be more easily evaluated and yield a return on investment within the limited time period of a likely future Model Test award.

9.4.2 Lessons Learned

Delaware's experience with the SIM Model Design process yields several lessons:

- **Senior-level engagement and leadership from both state agencies and private sector stakeholders are key to designing reforms.** As noted by one private sector leader, “When the Governor calls, you will answer the phone.” The state wields an important role in its ability to convene a cross-section of stakeholders and, if necessary, use the “bully pulpit” to enforce statewide reforms or activity. This state role, however, is only as powerful as the leadership supporting these actions, according to stakeholders, so high-level state leadership is necessary to yield high-level returns. Similarly, state actions are reinforced when high-level leadership from across stakeholder groups, especially prominent providers and payers across the state, are engaged and actively in support of proposed activities.
- **The state must strike a balance in its role as leader, facilitator, and participant in development of the Plan.** Most agreed that the state was the most appropriate entity to lead development of the Plan; several stakeholders lauded the overall approach taken by the state to convene and guide stakeholders through the Plan development process without “tak[ing it] over.” Similarly, many noted a need for the state to adopt a governance model for Plan implementation that is a partnership representing both public and private sector interests.
- **Use of outside consultants is valuable for subject matter expertise, logistical support, and an external perspective.** Especially in a small and somewhat insulated state, several stakeholders appreciated that a neutral external party facilitated Plan development. Stakeholders noted that, because of its expertise in leading similar work in other states, McKinsey was able not only to bring structure and ideas to the Plan development process, but also to enable state agency leaders to participate as stakeholders by freeing them from some of the administrative and logistical tasks involved in the process.
- **The Delaware work group structure yielded helpful inputs and outcomes, but was resource intensive and draining on leadership.** Stakeholders reflected many positive aspects of the work group structure used to garner ideas and input into the Plan, including the incorporation of public and private leaders across work groups and the staggered calendar of work group meetings. This level of effort was said to be possible because of many in-kind hours expended by volunteer work group leaders to

organize and prepare for the frequent summer meetings; but this was onerous for them, according to some leaders. Although overall appreciating the gains reaped from this process, one leader described the experience as “Very draining.... To me that was negative,” warning that “if you don’t have people committed to the process that will stick with you through it, it could fall apart.”

- **The short time frame had both benefits and challenges.** Stakeholders were mixed about the benefits and challenges of operating on what was perceived to be a condensed timeframe for the Model Design award. Some noted challenges that included inadequate time to build consensus among stakeholders around Plan details or to explore existing delivery system reforms in other states to determine which could be adapted and implemented in Delaware. But others noted the benefit of a shorter timeline, which helped in sustaining momentum in support of the Plan.

9.4.3 Potential for Implementation

Stakeholders expressed cautious optimism about the feasibility of implementing the Plan. Although overall stakeholders largely support the Plan’s proposed concepts, at the time of our interviews the state had released few details about its final contents. One stakeholder cautioned, “There have been many wonderful ideas... that sounded good on paper, but [will] fall apart in implementation because they have thousands of details that cannot be addressed.”

Several stakeholders cited specific concerns (e.g., timing, stakeholder commitment, and overall sustained success) related to lack of details of several key elements of the Plan—including governance, shared data systems, personnel training, total cost of care models, attention to population and public health strategies, and metrics. Additionally, although many expressed confidence that the state would move forward with some Plan elements regardless of CMS funding, they expressed a need to “slice and dice” the Plan to match resources available.

Especially critical to successful implementation of the Plan will be formation of the Delaware Center for Health Innovation, according to stakeholders. Whatever the final structure, the Center would need clear and powerful authority to successfully implement the Plan. The Center would also need to garner strong support across the spectrum of relevant stakeholders, including assurance to stakeholders that they would continue to have input into future policies and programs developed by the Center. The composition of board membership, for example, would send strong signals to stakeholder groups about which players in Delaware’s health care landscape would wield the most significant power in influencing implementation of the Plan.

A handful of stakeholders, including some providers and state officials, supported an incremental implementation approach that would include piloting of reforms prior to widespread change and full implementation. However, others countered with concerns that pilots might not be brought to scale, alluding to prior innovative state pilot programs that have not led to statewide transformation. In this view, without full-scale, statewide implementation, the state

may not reap population health improvements hoped for as a result of many of the proposed elements.

9.4.4 Applicability to Other States

Many stakeholders mentioned Delaware's small size as benefiting its ability to garner significant and widespread stakeholder buy-in, emphasizing the ability to have high participation in frequent face-to-face meetings and accountability across a small pool of stakeholder representatives: "Our sandbox is small so you have to play together. Everyone knows what you said in the last meeting." Size also affects the overall ability of the state to successfully implement proposed reforms across its small geography and population. As one stakeholder put it: "In a larger state, any recommendation would [need] to carve out smaller groups to try the Plan."

9.4.5 Limitations of This Evaluation

We conducted all stakeholder interviews prior to release of the final Plan; thus, comments reported in this chapter may not accurately reflect stakeholder opinions of the final Plan. We did not receive responses after multiple interview requests to several state agency representatives from the Department of Insurance, the Division of Social Services (Medicaid), and the Statewide Benefits Office. Thus, opinions from these state stakeholders are not reflected in this chapter.

9.5 References

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State of Delaware (2013, December). *Choose Health Delaware: Delaware's State Health Care Innovation Plan*. Supplied by CMS.

United Health Foundation. (2013). *America's Health Rankings: About the 2013 Annual Report*. Retrieved January 6, 2014, from <http://www.americashealthrankings.org/>.

Appendix Table 9A-1. Models and strategies proposed in the Delaware Health Care Innovation Plan

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|--|---|---|---|--|
| Statewide transition to outcomes-based payment models (pay for value or total cost of care) | Highmark BCBS Delaware and the Medical Society of Delaware’s ACO model and PCMH initiative, Beebe CAREs, Department of Health and Social Services programs to address frequent emergency department utilizers | Primary: beneficiaries with chronic conditions/“high-risk” patients | <p>Proposed state executive branch actions</p> <ul style="list-style-type: none"> *Require Medicaid MCOs to implement outcomes-based payment model beginning in 2015 *Development of statewide clinical guidelines by which to measure improved outcomes <p>Proposed state regulatory action</p> <ul style="list-style-type: none"> *Require providers to organize—through formal or virtual structures—into coordinated care models (e.g., ACOs, coordinated independent physician practices) to participate in new Medicaid payment models; requirements will include flexibility for minimal panel requirements and to allow for participation from behavioral health providers <p>Proposed state facilitation of system change</p> <ul style="list-style-type: none"> *Creation of the Delaware Center for Health Innovation Adoption of outcomes-based payment models by commercial payers Provider-payer negotiation for prospective reimbursement structures <p>Proposed federal action</p> <ul style="list-style-type: none"> Delaware will invite Medicare to participate in similar payment models | Department of Health and Social Services, Department of Social Services, Delaware Health Information Network, providers, payers, Health Care Commission, Deputy Attorney General |

(continued)

Appendix Table 9A-1. Models and strategies proposed in the Delaware Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|--|---|-----------------------|---|--|
| Infrastructure to population health “Healthy Neighborhoods” –community coalitions developed to integrate community and clinical services to address community needs | Many ongoing initiatives | General population | Proposed state executive branch action Responsibilities related to implementation assigned to Division of Public Health Proposed state facilitation of system change *Creation of the Delaware Center for Health Innovation In-kind contributions through commitment of full- or part-time resources to Healthy Neighborhoods | Population health committee of the Delaware Center for Health Innovation, Division of Public Health, local community organizations (e.g., schools, nonprofits, employers, public health, social workers, community health workers), medical providers (e.g., PCPs, charitable 501(c)(3) hospitals, behavioral health specialists, pharmacists, and nurses) |
| Workforce development Improved education and training, including creation of a semiannual forum for health care workforce training and retraining, promotion of innovative education methods (e.g., simulation labs), reduction of education/training costs, improved marketing of educational opportunities | Many ongoing initiatives | N/A | Proposed state executive branch action Reducing duplicative background checks among payers, providers, and the Department of State, and leveraging the common CAQH credentialing application Proposed state regulatory action *Simplify licensing requirements for certain practitioners (e.g., nurse practitioners) Proposed state facilitation of system change *Establish the Delaware Center for Health Innovation *Establish common role definitions for care coordinators Establish a Health Professions Consortium | Department of Health and Social Services, Health Care Commission, schools (high school through graduate), Delaware Health Information Network, Delaware Health Sciences Alliance, providers, care coordinators |

(continued)

Appendix Table 9A-1. Models and strategies proposed in the Delaware Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|---|---|---|---|--|
| <p>Delivery system infrastructure and support</p> <p>Support for coordinated, team-based, and value-conscious care, including support coaching for provider transformation and development of learning collaboratives to foster a dialogue among providers transitioning care delivery models</p> <p>Supports (e.g., clinical guidelines) to reduce variation in care delivery</p> | <p>Many pilot programs</p> | <p>Primary: Patients with chronic conditions; “super utilizers ” including patients identified in the top 5%–15% of need for care coordination and patients with chronic conditions</p> <p>Secondary: Patients seeking care in specialty settings (e.g., behavioral health, long-term services and support)</p> | <p>Improve capacity of providers to practice at the top of their license through improved education and implementation of guidelines that relinquish some lower-level responsibilities to others on the team</p> <p>Proposed state executive branch action</p> <p>*The Innovation Center Clinical Committee will identify existing guidelines, clarify where there are multiple guidelines, and develop guidelines where none exist to address select areas of high cost and high variation and a common scorecard of metrics for providers to track the impact of the transformation, and to publicize the results across the state</p> <p>Establish care coordination learning collaboratives</p> <p>Prequalify or certify vendors to source care coordinators, tools, and resources to providers</p> <p>Proposed state facilitation of system change</p> <p>*Establish the Delaware Center for Health Innovation</p> | <p>Providers, Department of Health and Social Services agencies, Delaware Health Information Network, payers, providers, The Innovation Center</p> |

(continued)

Appendix Table 9A-1. Models and strategies proposed in the Delaware Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|---|---|-----------------------|---|---|
| <p>Health IT and enhanced data analysis</p> <p>Patient-risk stratification tools to identify patients in the top 5%–15% of need for care coordination and foster communication patient care</p> <p>Payer claims-based tools for payers to implement outcomes-based payment models, evaluate and report on provider performance, and generate payment</p> <p>Web-based provider portal to enable the exchange of information between payers and providers</p> <p>Patient population management tools that will enable providers to better manage the overall health of their patients</p> <p>Development of guidelines and resource centers to help providers adopt and select/implement the supporting tools</p> | <p>Delaware Health Information Network’s HIE and Web interface; statewide public health databases; Medicaid Decision Support System</p> | <p>N/A</p> | <p>Proposed state executive branch actions</p> <p>*Enactment of policies and sustainable long-term funding options to support new Delaware Health Information Network initiatives</p> <p>Prequalification or certification of vendors to develop data analytics and other provider support tools related to the health IT and connection to the HIE.</p> <p>Proposed state facilitation of system change</p> <p>Tool development and data reporting by payers</p> | <p>Delaware Health Information Network, payers, providers</p> |

(continued)

Appendix Table 9A-1. Models and strategies proposed in the Delaware Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|--|---|-----------------------|---|--|
| Patient engagement Statewide social marketing and education campaign to communicate unified health and health care decision-making and utilization messages Publicly downloadable apps for patient health empowerment, access to care, and care coordination Patient portal: Web-based portal to enable patients to access their health information and evaluate and select the providers that will best meet their individual needs | None | General population | Proposed state facilitation of system change *Creation of the Delaware Center for Health Innovation | Delaware Health Information Network, the Innovation Center |

¹Policy levers include Medicaid waivers; federal grants (including Round 2 SIM award); state laws; state regulations; state investments (e.g., in public health programming); foundation grants; employer-led coalitions to drive change among providers, purchasers, or plans; state government-led coalitions, task forces, or commissions to drive voluntary change among providers, purchasers, or plans; state purchasing contracts; and state-level (Governor-initiated) executive policy directives.

Abbreviations: ACO = accountable care organization, BCBS = Blue Cross Blue Shield, CAQH = Council for Affordable Quality Healthcare, HIE = health information exchange, health IT = health information technology, MCO = managed care organization, N/A = not applicable, PCMH = patient-centered medical home, PCP = primary care provider.

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10. Hawaii

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Building on its unique island topography, collaborative spirit, and long-term commitment to the health needs of its population, Hawaii moved forward in its efforts to address current and future health care challenges through its State Innovations Model (SIM) Model Design process, known locally as Part II of the Hawaii Healthcare Project (THHP) and formerly referred to as the Hawaii Healthcare Transformation Initiative. This public-private partnership balances strong leadership from the Governor's Office with extensive stakeholder engagement.

Hawaii's goal is to improve population health, improve health care delivery, lower costs, and reduce health disparities between its residents in Oahu, the largest island where most specialized care is concentrated, and the neighboring island populations. The proposed Health Care Innovation Plan (the Plan) focuses on delivery of care through patient-centered medical homes (PCMHs) supported by networks of community-based care services and enhanced use of health information technology (health IT), including electronic health records (EHRs). Plan implementation is intended, as a consequence, to improve responsiveness to two issues: (1) the health and psychosocial needs of individuals who tend to require the highest level of care, and (2) future shortages in the health care workforce.

Among other legislative and regulatory levers to help implement the Plan, which are to be fleshed out early in its implementation, establishing a permanent state Office of Health Care Transformation is viewed as crucial. The goal of the Plan is to achieve statewide adoption of PCMHs, with 80 percent of state residents enrolled in a PCMH by 2017.

10.1 Context for Health Care Innovation

Hawaii Governor Neil Abercrombie created the Healthcare Transformation Coordinator position in 2011 to lead efforts to improve health care in Hawaii, coordinate collaboration across state agencies, and oversee implementation of the Patient Protection and Affordable Care Act (ACA). The Transformation Coordinator initiated the THHP, the public-private partnership that secured the Model Design award. The following key contextual factors were considered in shaping the Plan.

State demographics. Hawaii comprises eight islands, organized into five counties. Nearly 70 percent of Hawaii's 1.4 million residents live in the City or County of Honolulu, on the island of Oahu (US Census, 2010). This concentration of population has resulted in a corresponding concentration of specialized health care on Oahu. Residents on neighboring

islands may lack access to needed professionals on their home islands and face financial and logistical barriers in flying to Honolulu for care.¹

Hawaii is the most ethnically diverse state: approximately 40 percent Asian (Filipino and Japanese are the largest subgroups), 25 percent non-Hispanic Caucasian, 20 percent more than one race, 10 percent Native Hawaiian and Pacific Islander, and 9 percent Hispanic/Latino. Hawaii has a significant migrant population from Pacific Island nations, for which it provides Medicaid coverage (State of Hawaii, 2014; U.S. Census, 2010).

Health care coverage and status. Hawaii has promoted access to health care coverage for nearly 40 years through the 1974 Prepaid Health Care Act. This legislation mandated employer-sponsored health insurance for employees working 20 or more hours per week. As a result, Hawaii has the second lowest uninsured rate in the country, following Massachusetts.

Hawaii ranks second in the nation in health status, with the lowest adjusted mortality rate and the lowest rate of preventable hospitalizations. Although overall averages are strong, the state is concerned about health disparities related to geographic, racial/ethnic, and socio-economic characteristics. The neighbor islands have higher poverty rates and higher rates of chronic conditions and unhealthy behaviors, such as heavy drinking, than Oahu. The Native Hawaiian, Pacific Islander, and Filipino populations experience significantly higher than average rates of disease mortality and morbidity. Oral health is also a concern—only 11 percent of Hawaii residents have access to fluoridated drinking water, leading to increased tooth decay (State of Hawaii, 2014).

Health care delivery. The majority of physician practices in Hawaii are small, independent practices. All hospitals are nonprofit, and service delivery is dominated by two large health care systems, Queens Health Systems and Hawaii Pacific Health. Hawaii also has a network of 14 community health centers and two rural health clinics. Access to behavioral health services and dental care can be a challenge, particularly for the Medicaid population (State of Hawaii, 2014).

The Hawaii Medical Service Association (HMSA), a Blue Cross Blue Shield affiliate, and Kaiser Permanente are the state's two largest payers/insurers, with 60 percent and 25 percent of the commercial market shares, respectively. They are the sole payers for the new state health insurance marketplace and for state and county employees and retirees through the Employer Union Trust Fund (EUTF). They are also two of five Medicaid/CHIP and Medicare payers; Medicaid managed care is provided to eligible Medicaid and CHIP recipients through Med-

¹ Hawaii's geographic barriers are further illustrated by the loss of the Hawaii Department of Health Director, who died following a December 2013 plane crash off the coast of Molokai (Gutierrez, 2013).

QUEST and to eligible seniors and individuals with disabilities through QUEST-Expanded Access (QExA). United Health Care is the sole payer for TriCare (State of Hawaii, 2014).

PCMH experience. About 45 percent of Hawaii residents are enrolled in a PCMH. The recently completed Beacon Community project used learning collaboratives to expand PCMH participation on the island of Hawaii. On the provider side, Pay-for-Quality (P4Q) initiatives administered by HMSA and other health plans, including Med-QUEST, have been used to reward providers for Healthcare Effectiveness Data and Information Set performance measure results related to screening, preventive care, and disease management. HMSA’s analysis has demonstrated that PCMHs are more likely to meet quality benchmarks than non-PCMHs (State of Hawaii, 2014).

Workforce. Hawaii faces significant workforce shortages across the health care spectrum on both Oahu and the neighboring islands. High cost of living, low provider reimbursement, and geographic isolation each contribute to this ongoing challenge. The State of Hawaii Workforce Development Council, through a planning grant from the Health Resources and Services Administration, created a comprehensive Healthcare Industry Workforce Development Plan for 2011–2020—detailing shortages and identifying goals, strategies, and action steps to increase the primary care workforce by 20 percent by 2020 (Workforce Development Council, 2011). The workforce stakeholder committee involved many individuals who contributed to the Workforce Development Plan, including representatives from the University of Hawaii and the community college system (State of Hawaii, 2014). Stakeholders expressed concern that the confluence of an aging physician workforce, a majority of small “mom and pop” practices that will need to convert to EHRs, and the upcoming ICD-10 implementation will lead to increased rates of retirement, exacerbating physician shortages.

Data Infrastructure. The Hawaii Health Information Exchange (HHIE) has secured more than \$5.6 million in federal funding to create Hawaii’s electronic health information exchange (HIE). This will feed into the Nationwide Health Information Network, allowing providers to securely share patient health information electronically (HHIE, 2012). HHIE also helps providers convert to EHR systems and supports their meaningful use efforts through its Hawaii Pacific Regional Extension Center (HHIE, n.d.). In another initiative, the County of Hawaii initiated programs to support use of health IT to achieve measurable improvements in health care quality and population health (Hawaii Beacon, 2012).

Supportive political environment. Hawaii has a history of being supportive of health care reform. The state is expanding its Medicaid coverage in conformity with the ACA Medicaid expansion option, and is building its own health insurance marketplace, the Hawaii Health Connector (State of Hawaii, 2014).

10.2 Planning Infrastructure and Process

With leadership and hands-on direction from staff in the Governor's Office, the process to develop the Plan engaged a wide range of stakeholders. Many of the key individuals were known to Plan leadership, because Hawaii is a relatively small state that had begun the conversation concerning transforming health care delivery prior to receiving the Model Design award. Virtually all stakeholders considered the process to have been positive and productive, characterized by strong leadership and a collegial atmosphere. Limitations in participation by clinicians and community members were addressed through a series of focus groups and community forums.

State leadership and guidance. The Governor's commitment to the SIM Initiative was expressed through members of his staff leading the planning process. Overall guidance was provided by Hawaii's Healthcare Transformation Coordinator, who reports to the Governor's Director of Policy. She was responsible for the Model Design planning process, including serving as co-chair for each of the stakeholder groups; more broadly, she is responsible for implementation of the ACA and the coordination of health IT. The SIM Initiative Project Director, also in the Governor's Office, reports to the Coordinator. She participated as staff for each of the stakeholder groups. Contractors provided management support and actuarial services, facilitated community meetings, and conducted focus groups.

We heard almost universal acknowledgement and praise for the leadership provided by the Governor's Office. Stakeholders expressed their belief that having clear and strong leadership from the Governor's Office was a key difference between this and earlier initiatives in Hawaii and instrumental to its success.

Stakeholder engagement. As a small state that began its Plan development process as Phase II of THHP, many of the key stakeholders were identified through their participation in Phase I and other health system reform efforts. Additional stakeholders were identified by these stakeholders and Plan leadership.

To facilitate conversations concerning key issues during the planning process, seven stakeholder committees were established: (1) Multi-payer; (2) PCMH; (3) Workforce Development; (4) Behavioral Health; (5) Oral Health; (6) Community Care Networks; and (7) Health Information Technology. These groups fed into a Steering Committee. Supporting the goal of a public-private partnership, each committee was co-chaired by a private sector member and the Health Care Transformation Coordinator. Participants included payers and purchasers; providers; organizations supporting the health care infrastructure, particularly health IT; academics; representatives of mentally ill patients and racial and ethnic minorities; and state agency representatives and legislators. We identified more than 100 stakeholders who participated in one or more meetings of one or more stakeholder committees.

Each committee conducted multiple in-person meetings. Participation was also possible through teleconference. A Web site containing agendas, minutes, and materials presented during each of the committee meetings was maintained, available to the public and updated throughout the planning process (The Hawaii Healthcare Project, 2013). Stakeholders expressed the view that the proposals were not developed in a top-down process. Leadership and staff organized topics for agendas and coordinated across the complex matrix of multiple committees operating at the same time, yet allowed work groups to move forward with their ideas. The process was described as consensus building and voting occurred infrequently. Initial meetings of each committee discussed the goals of the Plan development process. Although the committees developed their proposals, they generally started from earlier ideas and initiatives developed prior to the SIM Initiative. Proposals were shared across committees, with the interaction of developing ideas presented through logic models. Eventually, Plan components were brought together in the Steering Committee. The process was described as “deliberative.” All stakeholders said they felt they had a voice in the final Plan.

Across the committees, state government participants included leadership from a number of agencies, including the Department of Health, Behavioral Health Administration, Department of Commerce and Consumer Affairs (insurance), Department of Human Services (Med-QUEST [Medicaid]), and the Executive Office on Aging. To enhance state agency involvement, the Governor’s staff conducted parallel ongoing meetings with agency staff during the Plan development process.

We heard agreement across stakeholders that committees included a wide range of stakeholders. But we also heard concern that the effort had greater support in the private sector than among state agencies, and that this might be because Plan implementation would likely impose new requirements for greater alignment and coordination of goals across agencies at a time when agencies already feel taxed by other policy changes. According to interviewees, it is likely that some state agencies may also lack sufficient experience in working together to give them confidence that their goals will be adequately addressed by the larger Model Design process.

Engaging practicing clinicians and the community. Stakeholders observed that practicing clinicians and patients (community members) were generally missing from the stakeholder engagement process (committee meetings). These stakeholders believed that many practicing clinicians considered the time commitment required to participate, including multiple lengthy meetings and travel time if attending in person, too onerous.

In response, Plan leadership engaged practicing clinicians and the community outside the committee process. The Area Health Education Center (AHEC), located at the John A. Burns School of Medicine (JABSOM), conducted a series of focus groups with a total of 105 providers—to elicit feedback on PCMH and care coordination network formation, administrative

simplification, optimal quality metrics, and approaches to integrating behavioral health services. Also, seven community meetings were conducted across six islands with 133 total residents attending.

State resources. No state funds were available for the planning process, other than for the Healthcare Transformation Coordinator’s salary. In-kind state contributions were provided through time spent by other state agency personnel. Two grants from the private sector, one from the hospital association and a second from the health plan association, funded several staff positions.

10.3 The Hawaii Plan

The Plan proposes strategies and models intended to promote innovative health care transformation statewide. Policy levers and ongoing consumer engagement initiatives further support the innovations planned in the state. Primary care practice redesign through the PCMH model forms the cornerstone of the Plan. Other key components include care coordination networks for high-risk/high-needs populations, investments in health IT (including increased connectivity and expansion of telehealth), and movement toward value-based purchasing among all payers.

Components of the Plan reflect the priorities elucidated during the stakeholder engagement process. Hawaii obtained agreement and approval from all stakeholder committees on the conceptual framework of the Plan (State of Hawaii, 2013). Ultimately, the Plan aims to achieve statewide adoption of the PCMH model, reaching 80 percent of Hawaii’s citizens (1 million people) and, over time, involving all payers and providers in care coordination programs. To ensure statewide implementation and sustainability of the proposed reforms, the state says it will seek to establish a permanent health care transformation administrative structure and thus continue its convener role to ensure the innovative models move forward. *Appendix Table 10A-1* provides a summary description of the planned innovations, initiatives on which they are built, populations they address, and supporting policy levers and entities.

10.3.1 Models and Strategies

In the Plan, Hawaii proposes 12 specific models and strategies to achieve its goals. The Plan categorizes these models and strategies under six broadly considered “catalysts” to transform the health care system in Hawaii: (1) primary care practice redesign (encompassing the first three models/strategies described below); (2) care coordination programs for high-risk/high needs populations (next five models/strategies); (3) payment reform; (4) health IT; (5) health care workforce enhancements; and (6) policy levers to drive these structural changes, including establishment of the Office of Health Care Transformation.

PCMH. Statewide adoption of the PCMH model is the centerpiece of the Plan's delivery system reform efforts, as noted, with the goal of 80 percent of all Hawaii residents (1 million individuals) enrolled in a PMCH by 2017, an increase from the current 45 percent (State of Hawaii, 2014). All plans and payers, including Medicaid, have agreed to payment incentives of a higher fee-for-service rate and PCMH payment to providers meeting the minimum standard established by the Hawaii Association of Health Plans, which is aligned with National Committee for Quality Assurance (NCQA) Level 1 criteria. However, instead of making official recognition from an accrediting body (i.e., NCQA) mandatory, health plans can determine if the providers meet the minimum standard. The longer-term goal is to continually increase the number of providers reaching NCQA PCMH Level 3 recognition.

The QUEST Integration program (the integration of Med-QUEST and QExA into one Medicaid managed care program expected in January 2015) is to serve as a lever for PCMH expansion, because Med-QUEST is requiring health plans to assign at least 80 percent of their members to a PCMH by 2017. Other strategies include learning collaboratives to train providers in practice redesign and practice transformation facilitation teams. These strategies specifically seek to ensure that independent providers and neighbor island populations are engaged in the changes. PCMH training programs are to be built into JABSOM's teaching sites.

Behavioral health care integration. The Plan calls for greater primary care and behavioral health integration through an increased number of behavioral telehealth consultations for Medicaid and Medicare patients with behavioral health conditions, increased screening for depression in federally qualified health centers (FQHCs) and other primary care settings, and increased co-location of behavioral health providers and primary care providers (PCPs) in practice and medical home settings (including increasing the number of co-located FQHC providers in behavioral health settings to four by 2015). Hawaii intends to create a Behavioral Health Coordinator and three policy analyst positions to further support integration within primary care and to provide learning collaboratives on behavioral health for primary care practices. The QUEST Integration program would support these integration efforts within the Medicaid population by expanding its coverage of behavioral health services to include specialized behavioral services, cognitive rehabilitation services, and habilitation services for certain populations.

Expanded telehealth. The Plan prioritizes expanded telehealth access and infrastructure. To date, localized telehealth models have successfully operated in the state. For example, the Department of Health, Child and Adolescent Mental Health Division, provided more than 1,000 telehealth patient visits in 2013 for mentally ill Medicaid children. Existing telehealth use remains limited for many rural areas, however, due to the expense of accessing the necessary telecommunications infrastructure, inadequate payments, and malpractice insurance issues. The Plan calls for dedicated staff to coordinate efforts around the state to develop a sustainable

telehealth business model. Federal telehealth grants are also to be pursued to support telecommunication capacity. Expanded telehealth services in PCMH practices and other settings are expected to enable primary care access and support specialty consultation to primary care practices. JABSOM and the University of Hawaii Telecommunications and Social Informatics Research Program (UH TASI) are to assist in the creation of “telehealth centers of excellence” to further the research and sharing of best practices for telehealth. In collaboration with existing programs like the UH TASI, JABSOM would lead consultations for providers implementing primary-to-specialist consultation and specialist-to-patient care using telehealth.

Medicaid health homes. Hawaii plans to develop Medicaid health homes (MHHs) to provide comprehensive care management and referral services to Medicaid recipients with specific chronic conditions—including severe and persistent mental illness, serious mental illness, serious emotional disturbance, or two of the following: diabetes, heart disease, obesity, chronic obstructive pulmonary disease, and substance abuse. The MHH model would incorporate use of community health workers (CHWs) and similar peer resources to facilitate linkages to social services in addition to medical and behavioral health services. In partnership with the Hawaii Primary Care Association, Med-QUEST is facilitating a stakeholder engagement process to draft an MHH state plan amendment to be submitted to CMS by July 1, 2014. To further incentivize provider participation and decrease administrative burden, compensation for MHHs would go directly to providers on a per-member, per-month (PMPM) basis, rather than being funneled through payers and plans.

Community care networks. Hawaii plans to develop community care networks (CCNs) to supplement support to independent PCPs and high-risk patient groups. CCNs would be modeled after MHHs, with similar criteria, services, aligned metrics, and standards. All payers—including the EUTF, commercial insurers, Medicaid, and Medicare—would provide direct compensation to CCNs for their services (in the case of Medicaid, for example, CCNs would receive payment directly rather than from the various health plans contracted under Med-QUEST). Some element of the payment to CCNs would incorporate a P4Q model. The CCN model would operate in a tiered fashion, with Tier 1 focused on patients at risk of developing chronic diseases and Tier 2 targeting patients with multiple existing chronic conditions, similar to MHHs. Many questions about how CCNs would be implemented—for example, what formal relationships they would have with PCPs, or how patients in each tier would be identified—have been left to a later phase of planning and implementation, though the Plan notes that there are examples in place elsewhere in the nation.

Super-utilizer pilots. Hawaii intends to develop programs to provide direct physical and mental health care, care coordination and management, and assistance with social services to patients who have frequent encounters with the health care system. Specific pilot programs outlined in the Plan address the following three high-risk/high-need super-utilizer populations

(totaling 1,000 individuals): (1) a behavioral health pilot for high-utilizers with other psychosocial risk factors such as homelessness, mental illness, and substance abuse; (2) a community paramedicine pilot focused on high users of emergency services in rural areas; and a Department of Public Safety super-utilizer pilot for individuals with frequent interaction with the justice system. Hawaii proposes that, during Phase 1 of Round 2 Model Test funding (the first 1.5 years), super-utilizer pilots would be implemented and used to develop and fine-tune approaches for coordinating enrollment with local partners and providers. Full implementation of super-utilizer programs would occur in Phase 2 (1.5 to 3 years from implementation).

Increased coordination for aged and disabled programs. Round 2 Model Test funding would be used to enhance and increase coordinated care programs for the aged and disabled populations. Funding would increase the number of seniors receiving services in existing age-in-place programs, care transitions programs, and healthy aging programs. Model Test funds would enable the Executive Office on Aging to expand and better monitor progress by Aging and Disability Resource Centers to develop the following patient-centered services: (1) post-hospitalization transitional care; (2) a participant direction option for arranging services under federal and state elder care programs, to avoid nursing home placement and Medicaid spend-down; and (3) counseling on home- and community-based services options for long-term supports and services. Specific services for the aged and disabled would also be incorporated into the overall PCMH model proposed for expansion under the Plan, including legal and financial planning, support groups for caregivers, and counseling. The Plan does not discuss how this strategy would coordinate with the Medicare program.

School-based health center expansion. The Plan proposes an expansion of school-based health centers with services that include mental health care into communities with community health centers and demonstrated need. Hawaii currently has one school-based health center and another pilot school-based behavioral health project. The Plan also calls for expansion of the Career Pathway system that engages school health aides to develop their skill sets. School-based health centers offer families access to medical homes and integrate behavioral health within primary care settings.

Payment reform: value-based purchasing and standardization. Hawaii seeks to continue all-payer discussions related to using payment models to support PCMH, super-utilizer programs, and telehealth. Building on HMSA and Med-QUEST P4Q initiatives, the Plan proposes to ultimately transition all payers to value-based purchasing, which could include P4Q, shared savings, or a PMPM payment method. To that end, key EUTF and Medicaid value-based purchasing requirements are to be aligned by 2017. An all-payer claims database (APCD) is planned for use in informing payment reforms going forward.

Hawaii has achieved multi-payer agreement on the principle of adopting a core set of P4Q metrics that will be part of the pay-for-performance criteria payers and plans are to establish

by June 30, 2014, and implement by January 1, 2015. Part of these criteria will include reimbursing PCMHs at a higher rate than non-PCMHs. Strategies to discourage “cherry picking,” including risk adjustment criteria for reimbursement, will be formulated by Medicaid, health plans, and the Office of Healthcare Transformation. Future state-convened multi-payer meetings will also seek to achieve consensus in 2014 on payment structures and standardized administrative requirements to minimize provider burden. Additional “safe harbor” provisions may be enacted to encourage payer collaboration on reform.

Increased health IT connectivity and capability. Health IT enhancements, both providers’ use of health IT and systems for enhanced data analysis, are essential for successful implementation of other components in the Plan. For example, the proposed PCMH and care coordination models would require accelerated utilization of EHRs, expansion of interoperable IT infrastructure for HHIE connectivity, and admission-discharge-transfer (ADT) feeds, along with increased analytic capabilities and data reports.

Hawaii has set specific goals in relation to its efforts to encourage health IT uptake in the state. The state aims to increase EHR adoption among primary care providers to 80 percent, an increase of 8 percent per year over a period of 3 years. The number of ADT automated alerts to PCPs is to increase by at least 10 percent annually. Standards for information exchange and communication of measures are to be established by January 1, 2015. Unique HIE users are to increase by 8 percent per year, with the total volume of information exchanged via HIE services up by 10 percent annually. The Plan expects that enhanced payment for PCMHs will be an incentive for practices to adopt EHRs, which are a requirement of being a PCMH. With Round 2 Model Test funding, Hawaii would provide assistance for EHR adoption to small independent practices; in addition, federal partners, state agencies, and existing entities, including HHIE, would continue to develop data infrastructure and tools for health IT connectivity across providers.

To inform policy and identify ongoing cost drivers, the Plan proposes to integrate and make available information on cost, quality, and metrics through an APCD and a state-developed Web site. Provision of technical assistance, in addition to existing incentives and penalties, would further encourage uptake and utilization of health IT among providers. The increased adoption of health IT tools and systems would enable greater data sharing and outputs—thus providing needed evidence to evaluate population health, health care costs and drivers, and the effectiveness of PCMH and other models.

Investment and development of the data infrastructure would support the state’s overarching goal to better understand and ultimately address health disparities. To enable Hawaii to explore the key factors that drive the social determinants of health, the state hopes to analyze data from the APCD and conduct future discussions with payers and stakeholders.

The Governor's Office of Health Care Transformation and the Hawaii Department of Commerce and Consumer Affairs have received a Center for Consumer Information and Insurance Oversight Cycle III Rate Review grant from CMS, in part to support development of an APCD. With Round 2 Model Test funding, the APCD datasets and functional capacity would be expanded.

Enhanced health care workforce development. Key workforce development strategies in the Plan include creation of a Health Interprofessional Workforce Center and support of a health care career pathway system in the community college system. Hawaii plans to leverage prior and ongoing workforce development infrastructure, including the Healthcare Workforce 20/20 Plan and the Pacific AHEC, to address Hawaii's significant workforce deficits. The University of Hawaii would also play a key role through creation of the Workforce Center, inclusion of the PCMH model within JABSOM's primary care training sites, and implementation of an advanced practice nurse practitioner residency program at the Mānoa School of Nursing and Dental Hygiene. Widespread adoption of the PCMH model is expected to help ensure that providers practice at the top of their licensure. Hawaii also proposes to expand its CHW training program to more effectively use these workers in meeting patients' behavioral health needs and ensure that training includes cultural competency skills to address health disparities. These activities are planned to converge to build a sustainable workforce development structure. A number of existing and proposed policy levers, including appropriation of funds for primary care training programs and medical school slots, would support the Plan's workforce strategies.

Sustainable health care transformation structure. The state plans to make structural changes to support long-term health care innovation and planning in Hawaii. State legislation has been submitted to make permanent the Model Design planning leadership entity as the new Hawaii Office of Health Care Transformation. And two companion state house and senate bills are being considered in the 2014 legislative session to establish an Office of Health Care Transformation and a "Health Care Transformation Special Fund." The Office would be housed within the current State Health Planning and Development Agency, to be renamed the Hawaii Health Care Planning and Policy Authority as part of the measure (Hawaii State Legislature, 2014). Requested funds would support additional program staff dedicated to health care transformation. The Office of Health Care Transformation, as a natural continuation of the work done by the Plan leadership, would convene public and private sector stakeholders, integrate ongoing and new initiatives, and align state agencies. Advisory committees would counsel the cabinet-level Health Care Transformation Officer on priorities and plans for health care reform. The Office would also house an Innovation Center responsible for managing the APCD, establishing transformation goals, and evaluating progress on meeting the goals.

Other models and strategies considered for the Plan but rejected. Overall, the Hawaii Plan encompasses the models considered and brought forward by stakeholders during the

SIM planning process. Stakeholders stated that the reform areas with greatest support in the state had already been identified during Phase I of THHP. For example, the decision not to consider a bundled payment model as an option for the Plan was based on feedback provided during the Phase I process.

Although the state convened an Oral Health stakeholder committee, that topic ultimately did not result in a prominent strategy within the Plan. According to stakeholders, this was due in part to a lack of comprehensive state oral health data and resistance from the state dental association. The PCMH model, however, is to include a checklist for dental screening and referral.

10.3.2 Policy Levers

To implement the above-cited strategies, the state and its partners plan to leverage new and existing legislative and regulatory actions, supported by structural changes (e.g., establishing the Office of Health Care Transformation) and cooperation of public and private entities. *Appendix Table 10A-1* provides detailed information on relevant policy levers for each component of the Plan.

Hawaii has an existing policy infrastructure that positions it well to move forward with Plan implementation. This infrastructure includes the Prepaid Health Act of 1974, which facilitated a relatively high rate of health care coverage for its population and enables most Hawaii residents to access health care through the models proposed in the Plan. Hawaii's statutes support the HIE. The state's most recent renewal of its Medicaid section 1115 waiver consolidates its Medicaid managed care programs and streamlines eligibility under the QUEST Integration program. The QUEST Integration program will support transformation efforts by Medicaid health plans in numerous areas; for example, the state's QUEST (Medicaid) contracts with health plans will obligate them to pursue value-based purchasing and EHR use, expand coverage for behavioral health services, and encourage patient-centered approaches in care coordination.

The state plans to pursue new actions to further strengthen its position to assemble key stakeholders and implement change. As described above, establishment of a permanent Office of Health Care Transformation in the state government is viewed as a necessary step for sustained transformation in the state. Legislation is being put forward to codify and fund the Office. The executive branch plans to take steps to continue its convener role through the oversight of advisory committees to the Office and formation of a Public Health Policy Group in 2015. The Office would also convene quarterly data analysis and policy dissemination meetings with public and private partners. To further support innovation in payment structures, the Medicaid and EUTF programs would align and reissue contracts to include such requirements as submission of data to the APCD and value-based purchasing. The state also anticipates

leveraging the Hawaii Health Connector, its nascent online exchange, to support transformation efforts.

Hawaii proposes to make new investments to support Plan implementation and seek additional federal funding. For example, state-level appropriations for primary care training programs and medical school slots would underwrite the Plan's workforce development component. Round 2 Model Test funding would go toward enhancing and expanding existing health IT, workforce development, and care coordination programs in the state. In addition to the Round 2 Model Test award, Hawaii plans to pursue other federal funding opportunities in such areas as telehealth.

With regard to legislative levers, most in the Plan are under consideration rather than in process. For example, the state plans to consider pursuing expanded "safe harbor provisions" in 2015 beyond legislation passed in 2013—further protecting providers and payers so they can collaborate in the manner envisioned by the Plan on payment and health care system reforms. To support its model for expanding telehealth, legislation may be required to change licensing standards or the definition of practitioners' scope of practice. Finally, the Hawaii legislature will likely consider a "health in all policies" statute, according to stakeholders, requiring consideration of the health aspects for non-health related planning.

Additional policy levers would be required in the future, and are to be considered during early stages of implementation of the models. These include legislation requiring participation in APCD for commercial plans and providers and standardization of reported racial/ethnic data. Additionally, legislation may formalize the role of the HHIE and the state's participation in it. Generally, the proposed models do not require legislative or regulatory action; rather, they can be reached through collaboration and consensus among relevant stakeholders.

10.3.3 Intended Impact of the Plan

The Plan focuses on statewide innovation, with particular concern for underserved individuals and high-need communities. The Plan outlines strategies to achieve statewide adoption of the PCMH model, with the goal to have 80 percent of Hawaii residents enrolled in a PCMH by 2017. Hawaii's transformation efforts specifically aim to improve population health metrics for diabetes, obesity, heart disease, and end-stage renal disease. Following additional planning and discussions, all payers and health plans in the state are expected to agree to standardized metrics, processes, and payments in the long term. Care coordination and practice redesign initiatives specifically address high-need populations with known disparities; inhabiting rural neighbor islands; or with chronic, complex conditions that may be the sequelae of psychosocial problems. Concern for addressing health disparities runs throughout the Plan.

10.3.4 Proposed Next Steps

Next steps for Hawaii include completion of actuarial analyses and submission of an application for a Round 2 Model Test award. The Model Design process has propelled the state to pursue new, permanent structures for planning health care innovation via state legislation to further supplement Model Test funding. Health plans and payers expect to continue meeting to discuss alignment on metrics and administrative requirements. Work on the health IT infrastructure in the state is also to continue. Under the leadership of the Governor’s Office and the proposed State Office of Health Care Transformation, Hawaii hopes to continue health care innovation planning and implementation, regardless of Model Test funding.

The Plan calls for a phased approach to implementing the proposed models. Models of care implemented as part of primary care practice redesign and increased care coordination for patient populations are to be implemented through two phases over 3 years. Phase 1 would include development of PCMH and MHHs, establishment of practice facilitation teams and learning collaboratives, three pilot super-utilizer programs, health IT development, construction of the APCD and alignment of value-based purchasing requirements, creation of a CCN taskforce, and increased integration of behavioral health care within those initiatives. The primary policy strategies to create the necessary supporting infrastructure to guide implementation would also be pursued in that period. During Phase 2, the CCN model and super-utilizer programs would be fully implemented, alongside continued advancements in behavioral health delivery and payment reforms. Development of a state Web site, with cost and quality data and increased analytic capacity for the APCD, is also anticipated for Phase 2.

10.4 Discussion

The planning process for the Plan was developed during a period of rapid and unavoidable change in the health care delivery system, including pressure for improving access and quality of care, while further containing costs. We asked all stakeholders, “why now?” We wanted to understand the confluence of influences that appeared to effectively bring a wide range of individuals to the table to work to change health care delivery in Hawaii. The primary stakeholders said they believed health system change was inevitable; therefore, they needed to participate. Once at the table, they found many of their colleagues there as well. Plan leadership was said to promote a positive environment, resulting in an effective series of planning sessions.

10.4.1 Critical Factors Shaping the Plan

Several factors stand out as prompting the decisions Hawaii made about the models, strategies, and policy levers included in the Plan.

Pre-planning efforts facilitated efficiencies. Because many of the stakeholders engaged in the process had recently worked together on other initiatives, they brought to the

table a shared baseline for what they should be focusing on. Similarly, Plan leadership knew from the outset which strategies were more likely to have widespread support from stakeholders (e.g., PCMH).

Strong leadership and political support. The legitimacy of the SIM planning process was expressed through leadership, including hands-on involvement of staff in the Governor’s Office. This helped bring various constituencies to the table, including previously siloed state agencies and private sector competitors. As one stakeholder put it: “People understood from the beginning that we were really intending to make some changes.”

Culture of collaboration. Many stakeholders described Hawaii as having a general culture of collaboration and treating others respectfully. In addition, the insurance market and the hospital systems are dominated by a few large companies. Political discourse in the state is led by one party, and academic support was received from the state’s one medical school. These factors may have helped the Model Design process maintain focus and develop an implementable Plan.

10.4.2 Lessons Learned

Two lessons learned during the Plan development process may be valuable to other states, according to stakeholders.

Front-end planning is critical. The Model Design initiative was inclusive of a large number and variety of stakeholders, representing interests throughout the state. Stakeholder participants expressed their unanimous support for this approach while acknowledging that it required “time, energy, and effort.” Front-end planning was said to be critical due to the limited time to convene meetings with a large number of participants, discuss complex issues, and make decisions. It was not possible to start from scratch, according to this view; ideas to begin the discussion included earlier efforts in the state and knowledge of what other states were doing.

Developing a good general idea into an actual, specific, definable project that can be delivered is a challenge. Stakeholders may reach consensus that an idea is a good one but, as one stakeholder said: “where the rubber really hits the road is when we start defining exactly what we’re going to change first, how that’s going to happen, and by when.” In other words, a good plan is one that can be implemented.

10.4.3 Potential for Implementation

The state leadership expressed concern about its ability to maintain the process after the Model Design award ended, especially continuing the momentum past a short planning period since stakeholders have “real jobs” they need to focus on. The state was seeking ongoing staff funding through grants and state legislation to support the creation and funding for the planned

new Office of Health Care Transformation. However, given the timing of the legislative session, this could not feasibly occur before July 2014.

10.4.4 Applicability to Other States

Hawaii includes rural and geographically isolated communities. Although they may not face the same degree of isolation, stakeholders said other states may find useful Hawaii's consideration of new models of care for isolated rural areas without having to come to the "mainland," particularly in relation to health IT and telemedicine.

To the extent practicable, stakeholders also said other states may also wish to use Hawaii's effective front-end planning strategies to help guide their own planning of new initiatives within a limited time frame.

10.4.5 Limitations of This Evaluation

All stakeholder interviews were completed prior to submission of the final Plan, so this analysis may not accurately reflect stakeholders' opinions of the final Plan. In addition, there may be response bias from stakeholders who would like Hawaii to receive additional funding from the Innovation Center. Finally, we wish to express our deep sadness for the loss of Hawaii's Health Commissioner in the 2013 plane crash, whose insights were included in the development of this case study.

10.5 References

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Appendix Table 10A-1. Models and strategies proposed in Hawaii Health Care Innovation Plan

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|---|--|---|---|--|
| PCMH Model | Single-payer PCMH programs (Med-QUEST PCMH, HMSA PCMH, Kaiser Permanente PCMH program) HIBC | General population goal: 80% of HI residents enrolled in a PCMH by 2017 | Existing QUEST Integration Medicaid section 1115 waiver—integration of Medicaid managed care programs for all beneficiary groups (in process) Proposed state executive branch actions *Development of practice transformation facilitation teams Intensified training and increased number of PCMH learning collaboratives Medicaid Health Home state plan amendment State facilitation of system change *Provider participation *All plans and payers have already agreed to reimburse at a higher level those providers who meet NCQA PCMH L1 criteria | Health plans and payers Regional Extension Center Contracted vendor to develop practice facilitation teams and learning collaboratives JABSOM |
| Behavioral health care integration | | Patients with behavioral health conditions; high-risk populations | Proposed state executive branch actions Establish positions of Behavioral Health Coordinator and three policy analysts QUEST Integration Medicaid section 1115 waiver (in process) | JABSOM, FQHCs, providers and health plans |
| Expanded telehealth | Department of Health, Child and Adolescent Mental Health Division telehealth program Pacific Basin Telehealth Resource Center | General population; underserved patients and regions lacking access to specialty care; Medicare and Medicaid patients with behavioral health conditions | Existing Hawaii Rev. Stat. §431:10A-116.3, §432:1-601.5, §432D-23.5 (Coverage for telehealth) Proposed review of state legislation/regulation Development of incentives and malpractice coverage Proposed federal actions *Telehealth grants | JABSOM and UH TASI HI Department of Health Local Payers Other stakeholders already engaged in telehealth |

(continued)

Appendix Table 10A-1. Models and strategies proposed in Hawaii Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|--|---|--|--|---|
| Medicaid Health Homes | Med-QUEST PCMH | Medicaid recipients with severe and persistent mental illness, serious mental illness, and serious emotional disturbance; Medicaid recipients with two of the following conditions: obesity, chronic obstructive pulmonary disease, substance abuse, heart disease, diabetes | Proposed state legislative actions Medicaid Health Homes state plan amendment (to be submitted by July 1, 2014) (in process) | Health home team providers HI Dept. of Human Services Med-QUEST (Medicaid) Division Hawaii Primary Care Association |
| Community Care Networks (CCNs) | HIBC P4Q initiatives | EUTF and commercial insurance patients with needs beyond scope of PCMHs | To be determined. | State Office of Health Care Transformation CCN Committee convened for planning All payers: Medicare, Medicaid, EUTF, and commercial payers Health IT entities |
| Super-utilizer pilots 3 Pilots: Behavioral health pilot Community paramedicine pilot DPS super-utilizer pilot | | Super-utilizer populations: Patients with history of high utilization, have other psychosocial risk factors, or are referred High users of emergency services in rural areas | State executive branch action QUEST Integration Medicaid section 1115 waiver (in process) Proposed federal action *Round 2 Model Test award | Providers, health plans, and community agencies Community Health Centers HI Dept. of Health Emergency Medical Services and Injury Prevention Branch DPS Health IT entities |

(continued)

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Appendix Table 10A-1. Models and strategies proposed in Hawaii Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|--|--|--|---|---|
| Increased coordination for aged and disabled programs | ADRC Medicare’s Community-based Care Transitions Program Home- and community-based services Participant-directed services programs Kupuna Care Veteran-directed movement in HI QUEST Integration Enhanced fitness and chronic disease self-management programs | Individuals with frequent interaction with the criminal justice system with a mental health diagnosis or history of substance abuse Aged and disabled | Existing Section 3026 of the Affordable Care Act (Community-based Care Transitions Program) Older Americans Act Title IIIB (legal assistance) Proposed federal action *Round 2 Model Test award | PCMHs, Medicaid Health Homes, CCNs Other primary care providers and hospitals, Veterans Affairs Medicare, Medicaid Executive Office on Aging , Department of Health Local county ADRC |

(continued)

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Appendix Table 10A-1. Models and strategies proposed in Hawaii Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|--|---|-----------------------|---|--|
| School-based health centers expansion | The Kahuku School-Based Health Center at Kahuku High and Intermediate School, operated by the Ko'olauloa Community Health and Wellness Center Queen's Medical Center and Tripler Army Medical Center school-based mental health care program at Wahiawa Elementary School Career Pathway System for school health aides | Children and families | To be determined. | Community health centers Hawaii Department of Education Hawaii Alcohol and Drug Abuse Division |
| Payment reform: Value-based purchasing and standardization | HMSA and MedQUEST P4Q initiatives | N/A | Existing *Effective in 2015, MedQUEST will require health plans to include value-based purchasing in 50% of all contracts with PCPs and hospitals in the first contract year, 65% in year 2, and 80% in year 3 Proposed state legislative action Passage of additional definitions for Safe Harbor provisions (in 2015) Proposed state regulatory action Reissuance of EUTF and Medicaid contracts Proposed federal action *Round 2 Model Test award | EUTF, Medicaid Eventually all payers |

(continued)

Appendix Table 10A-1. Models and strategies proposed in Hawaii Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|--|--|---|--|--|
| Increased health IT connectivity and capability Technical assistance to providers to increase EHR adoption and utilization of Health Information Exchange (HIE) APCD datasets and functional capacity Development of data infrastructure and analytics platforms | UCERA telemedicine technology HIBC HHIE Development of an APCD under way with funding from CCIO | General population and health care system, with focus on primary care providers | Existing *CCIO Cycle III Rate Review grant (provides funding for an APCD) Stage 2 Meaningful Use incentive program 2012 Memorandum of Agreement between the State and the HHIE (outlines collaboration to develop a statewide health information network) Proposed state regulatory action Reissuance of EUTF and Medicaid contracts Proposed federal action *Round 2 Model Test award | State agencies and offices (Office of Information and Technology, State Office of Health Care Transformation, Department of Commerce and Consumer Affairs) HHIE Hawaii Health IT Committee All payers and providers |
| Enhanced health care workforce development Establishment of practice facilitation teams and learning collaboratives | Hawaii’s Healthcare Workforce 20/20 Plan & Report (2011) [<i>Plan developed but not implemented</i>] Physician Workforce Assessment Hawaii community college system’s “Career Pathway” program | General population, with focus on Health Professional Shortage Areas | Existing Hawaii State Loan Repayment Program HRSA Healthcare Workforce Planning Grant to State of Hawaii Workforce Development Council Advanced Practice in Nursing grant (Robert Wood Johnson Foundation) to increase percentage of baccalaureate-prepared nurses C3T: Community College Career and Technical Training Grant | Department of Labor Workforce Development Committee College of Health Sciences and Social Welfare at UCERA Hawaii /Pacific BasinAHEC |

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Appendix Table 10A-1. Models and strategies proposed in Hawaii Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|---|--|-----------------------|---|---|
| Univ. of Hawaii : creation of an Interprofessional Health Sciences School, implementation of the PCMH model in JABSOM primary care training sites, implementation of an advanced practice nurse practitioner residency program Support of a health career pathway system Expansion of Community Health Worker curriculum and programs | | | Proposed state legislative action HB 1742: appropriation of funds for an interdisciplinary primary care training program at Hilo Medical Center HB 1383: appropriation of funds to double primary care slots at JABSOM in next fiscal year | Primary care physicians, nurse practitioners, nurse midwives, physician assistants, psychologists, clinical social workers, dental hygienists, dieticians |
| Sustainable health care transformation structure The Office of Health Care Transformation | Healthcare Transformation Program in the Governor’s Office The Hawaii Healthcare Project (public-private partnership) | N/A | Existing Act 224 (Health Care Administrative Uniformity), signed 2013 Proposed state legislative action *Passage of HB2277 and SB2827 to establish the Office of Health Care Transformation within the State Health Planning and Development Agency and establish the Health Care Transformation Special Fund (in process) *Approval of funds for staffing the Office of Health Care Transformation Proposed executive branch action Formation of a “Public Health Policy Group” | State government and agencies, private and public sector |

¹Policy levers include Medicaid waivers; federal grants (including Round 2 SIM award); state laws; state regulations; state investments (e.g., in public health programming); foundation grants; employer-led coalitions to drive change among providers, purchasers, or plans; state government–led coalitions, task forces, or commissions to drive voluntary change among providers, purchasers, or plans; state purchasing contracts; and state-level (Governor-initiated) executive policy directives.

Appendix Table 10A-1. Models and strategies proposed in Hawaii Health Care Innovation Plan (continued)

Abbreviations: ADRC = Aging and Disability Resource Center, AHEC = Area Health Education Center, APCD = all-payer claims database, CCIO = Center for Consumer Information and Insurance Oversight, CCN = community care network, DPS = Hawaii Department of Public Safety, EHR = electronic health records, EUTF = Employer-Union Trust Fund, FQHC = federally qualified health centers, health IT = health information technology, HHIE = Hawaii Health Information Exchange, HIBC = Hawaii Island Beacon Community, HMSA = Hawaii Medical Service Association, HRSA = Health Resources and Services Administration, JABSOM = University of Hawaii John A. Burns School of Medicine, N/A = not applicable, NCQA = National Committee for Quality Assurance, P4Q = Pay for Quality, PCMH = patient-centered medical homes, PCP = primary care provider, UCERA = University Clinical Education & Research Associates, UH TASI = University of Hawaii Telecommunications and Social Informatics Research Program

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11. Idaho

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As a mountain state with large and sparsely populated rural and frontier areas, much of the state is served by small primary care practices that lack the resources for primary care transformation. A core group of Idaho stakeholders began to process of plan for reform by envisioning networks of patient-centered medical homes (PCMHs) delivering team-based health care that would improve access and quality and alleviate workforce issues. The State Innovation Model (SIM) Model Design award provided Idaho with an opportunity to engage stakeholders to develop their vision into a detailed Health Care Innovation Plan (the Plan)—building broad support to expand the Idaho Medical Home Collaborative’s current PCMH pilot and to leverage the existing Idaho Health Data Exchange infrastructure.

Idaho’s planning process was sponsored by the Governor, with legislators actively engaged. In keeping with the state’s tradition of building consensus rather than using government action, health care stakeholders were the driving force in design, particularly primary care providers (PCPs) and payers. The planning process was chaired by a physician and facilitated by the state’s consultant, Mercer. The process also featured extensive engagement of consumers, providers, and employers through focus groups and town hall meetings.

Key elements of the Plan include developing infrastructure at the state and regional levels to support PCMHs, implementing multi-payer PCMH payments, and building health information technology (health IT) to facilitate data sharing and quality measurement. To implement the Plan, the Governor has issued an executive order establishing the Idaho Healthcare Coalition, to be led by public and private stakeholders under the management of the Department of Health and Welfare. Implementation would build on existing initiatives using a combination of voluntary stakeholder action, use of state purchasing power and policy alignment, and a new Medicaid state plan amendment (SPA). The Plan’s goal is to focus on improving health and wellness care for the population as a whole, with 80 percent of state residents projected to have access to a PCMH by 2019.

11.1 Context for Health Care Innovation

The Plan was shaped by previous state efforts to advance PCMHs, strong physician leadership, and a preference for advancing health policy by building consensus among private and public sector stakeholders rather than through government action. It was also strongly influenced by a need to increase numbers of health personnel (including PCPs, specialists, behavioral health providers, and nonphysician providers) and the rural nature of the state.

The state chose to leverage an existing initiative, the Idaho Medical Home Collaborative, created by Governor C.L. “Butch” Otter in 2010 through executive order. The Collaborative includes PCPs, private insurers, Medicaid, and health care organizations, but not the Indian Health Service (Idaho has six recognized tribes in its jurisdiction). The Collaborative established a 2-year multi-payer pilot program that began on January 1, 2013, and has 36 participants—all primary care clinics (Idaho Medical Home Collaborative, n.d.). The state’s three largest private payers, Blue Cross of Idaho, Regence Blue Shield of Idaho, and PacificSource, which together cover over 57 percent of Idahoans, are participating in the pilot in addition to Medicaid, which covers 9.5 percent of the population (SHADAC, 2012). Participating practices must meet National Committee for Quality Assurance Level 1 accreditation standards by the end of the pilot’s second year (Idaho Medical Home Collaborative, n.d.). The pilot serves chronically ill patients and those with complex conditions. Medicaid’s participation in this pilot is authorized under a Section 2703 health home SPA for Medicaid individuals with chronic conditions.

Idaho’s model was also informed, in part, by Community Care of North Carolina, which provides a system of regional and state-level support for PCMHs. In 2012, a team of provider associations and Idaho Medicaid representatives studied the North Carolina model through an intensive 2-day visit to that state. During the visit, the Idaho team identified how the model could be adapted to Idaho and formulated goals that helped inform the Plan and complemented the Idaho Medical Home Collaborative.

Several other existing initiatives laid groundwork for the Plan. For example, the Idaho Health Data Exchange, a nonprofit that governs Idaho’s health information exchange (HIE), is to help lead much of the Plan’s health IT improvements going forward. Currently, 46 percent of providers use electronic health records (EHRs), and the HIE is connected to 10 hospitals, six labs, three payers, and more than 1,200 provider groups (State of Idaho, 2013b). Although a start, there is significant room for health IT developments in the state, particularly in rural areas and small practices. Also, the Idaho Behavioral Health Partnership (a recently implemented Medicaid managed care program that delivers only behavioral health services) laid the foundation for integrating behavioral health into the Plan. This foundation is critical, as Idaho has identified access to behavioral health services and integrating them with primary care as key challenges.

The health care workforce and delivery system capacity in Idaho is under resourced, serving as an impetus for the improvements in the Plan. Currently, 96.7 percent of Idaho is federally designated a health professional shortage area in primary care; for mental health care, 100 percent of the state is federally designated a shortage area (State of Idaho, 2013b). Many practices in rural areas are small and under resourced; 35 of Idaho’s 44 counties are rural, encompassing about 33 percent of the state (Rural Assistance Center, 2013; State of Idaho, 2013b). Further, Idaho has no medical school, so recruiting and retaining physicians is difficult.

Governor Otter created the Idaho Health Professions Education Council in 2009 to address these issues.

Idaho's political climate is one that favors voluntary action over state regulation to make changes in the health care environment. As a result, the Plan generally avoids identifying legislative policy levers and instead focuses on opportunities to expand existing private sector initiatives and federal authorizations for changes in Medicaid.

11.2 Planning Infrastructure and Process

State officials saw the SIM Initiative award as an opportunity to build on previous PCMH initiatives, including the Idaho Medical Home Collaborative and Medicaid Section 2703 health homes. Those initiatives created a core group of informed and engaged stakeholders with a common vision of implementing medical homes statewide. The Governor's sponsorship and the support of the Department of Health and Welfare director helped bring other key stakeholders to the table. A wide range of stakeholders were engaged in the design process, particularly health care stakeholders and key legislators. There was also extensive engagement of consumers, providers, and employers around the state through focus groups and town hall meetings.

Governance and management. Department of Health and Welfare staff managed the project as well as oversaw the contract with Mercer, which facilitated the planning process, conducted focus groups and town hall meetings, and wrote the Plan. The Department of Health and Welfare's director was not actively involved, but a deputy director and the Medicaid division administrator played key roles in shaping the initial direction of the SIM Initiative proposal, selecting and recruiting stakeholders, and quietly guiding the process in collaboration with stakeholder leaders. The Governor's Office was represented on the Stakeholder Committee and monitored the process to ensure the strategies and the Plan represented a consensus among participants and would be supported by stakeholders across the state. The Governor's Office did not try to influence the process or promote specific goals, however.

Stakeholder engagement. The state recruited the CEO of Idaho's family practice residency program to chair the Steering Committee and oversee the process. He and a state official identified and recruited a wide range of stakeholder groups to participate in the planning process. Both also held meetings and phone calls with individual stakeholders to better engage stakeholders and identify issues they were reluctant to raise in meetings. Stakeholders engaged in the planning structure included PCPs, community health centers, hospitals, the major commercial insurers, Medicaid, health care infrastructure, key legislators, the health division, and other state agencies (Mercer Health & Benefits, LLC, 2013). Idaho does not have an in-state medical school, but the family practice residency program was actively involved, as were the community health centers. The planning structure engaged stakeholders from around the state,

including physicians from small, rural practices. A state official noted that Idaho is small enough that they really could seat all the key health care stakeholders at the table.

The participation of non-health care stakeholders on the Steering Committee and work groups was limited to an employer, two legislators, and a state official representing advocates from the Commission on Aging. Several health care stakeholders said that more participation of self-insured employers in the planning process would have been helpful. Neither behavioral health providers nor consumer advocacy groups were engaged in committee work, but were instead recruited to participate in focus groups and town halls. Stakeholders participating in the planning process agreed that the focus groups and town hall meetings provided ample input from consumers and providers. Employers were also engaged through an employer focus group in each region. A representative from the Idaho Employers Health Coalition has been invited to join the newly formed Idaho Healthcare Coalition.

Planning structure. The state developed a new planning structure with a Steering Committee and four stakeholder work groups, which met monthly for 6 months. Members of these committees included members of existing planning entities and new participants. The Steering Committee comprised 11 voting members: three independent physicians, the chairs of the Idaho Senate and House health and welfare committees (one a physician), a representative from the Governor's Office, two other state officials, an employer, and two hospital system executives (one a physician).

The Steering Committee was supplemented by 13 "sponsors" representing key stakeholder groups—including the hospital association, the medical association, and the largest commercial insurers, as well as the four work group chairs (three of whom are physicians). The sponsors' role was described as adding their expertise, experience, and stakeholder perspective. The major distinction between the sponsors and members was that sponsors were nonvoting. As several participants explained, the sponsors participated fully in the Steering Committee, except for voting, and decisions were made by consensus if possible. This unusual structure, which relegated some powerful stakeholders to nonvoting roles, seemed to be accepted by both voting and nonvoting members (see [Table 11-1](#)). As of January 1, 2014, however, following submission of the Plan, the SIM Initiative Steering Committee agreed that all members would be voting members going forward.

Work groups. The membership of the four work groups reflected the composition of the full Steering Committee; most members were health care providers, health IT managers, or payers. Each work group had about a dozen members, and only one individual was recorded as nonparticipating. The work groups were: Network Work Group, assigned to plan regional and state networks to support PCMHs; Health Information and Technology; Clinical Quality; and Multi-Payer. Six physicians served on the Network Work Group, and eight on Clinical Quality. Multi-Payer included Medicaid and the three commercial insurers, and its membership

overlapped with that of the sponsors (Mercer, 2013). Physicians chaired three of the work groups, while the fourth was chaired by the director of the nonprofit Idaho Health Data Exchange.

Table 11-1. Idaho Planning Structure for Stakeholder Participation

| Steering Committee | | | |
|--|---|---|---|
| Voting Members | | Nonvoting “Sponsors” | |
| 11 members, including physicians, the Governor’s Office, and 2 legislators | | 13 members, including 3 physicians, 4 payers, and 4 provider associations | |
| Stakeholder Work Groups | | | |
| Multi-Payer | Network | Clinical Quality | Health IT |
| 11 members, including 4 payers, an employer, and 3 state officials | 14 members, including 6 physicians and various provider organizations | 11 members, including 8 physicians | 12 health IT specialists and representatives from provider organizations and state agencies |
| Focus Groups | | Town Hall Meetings | |
| 44 focus groups for consumers, primary care providers, other providers, hospitals, and employers | | 6 town hall meetings, including 1 on a reservation; also a briefing for tribal representatives and a consultation for 1 tribe | |

Abbreviations: health IT = health information technology.

Consumer/community engagement. The state used Mercer to undertake a major effort to engage consumers, as well as providers and employers, through a series of 44 focus groups and six town hall meetings to cover every region in the state. In each of four regions, multiple sessions were convened to solicit input from separate focus groups of consumers, PCPs, and other providers on each of the four work group topics, plus an employer group and a hospital group. Town hall meetings were conducted to engage the public and stakeholders in rural and frontier communities, where it might be difficult to recruit enough participants for separate focus groups. The state reached out to the state’s six American Indian and Alaskan Native tribes through a briefing, an on-site consultation with one interested tribe, and a town hall meeting on another tribe’s reservation.

Mercer compiled feedback from focus groups and town halls, and presented it to the work groups and Steering Committee. This feedback was considered during Plan development and helped shape the Plan; but it is not possible to tie any specific recommendations in the Plan to that input. Stakeholders reported that they took community engagement seriously as part of the effort of building support across the state and identifying potential concerns.

Planning resources. Several key state officials were actively engaged in the planning process, but the state relied heavily on Mercer to staff the process. Mercer staff facilitated the process by taking notes and reporting decisions from previous meetings and other work groups,

but stakeholders were clearly in control. Several stakeholders praised Mercer’s effective management of the process, including the extensive community engagement.

11.3 The Idaho Plan

The core of the Plan is to create PCMHs statewide for all patients, building from the Idaho Medical Home Collaborative (36 participating practices), and to strengthen linkages between the PCMHs and other health and social services. The state’s three largest payers and Medicaid are committed to the model. Although the Plan calls for Medicare engagement, Medicare has not committed to (nor did Medicare representatives participate in) the planning process. Under the Plan, the state would implement the PCMHs through the Idaho Healthcare Coalition, and through seven regional collaboratives, which would assist locally with PCMH transformation. Idaho’s Medicaid agency is already using its existing Section 2703 health home SPA for Medicaid beneficiaries with chronic conditions, and is planning to submit an integrated care model (ICM) SPA to allow additional Medicaid and Children’s Health Insurance Program (CHIP) participation in the PCMHs. Idaho also intends to make any necessary modifications to its existing Title XIX (Medicaid) and Title XXI (CHIP) state plans. The state does not plan to use any mandates or legislative levers to implement the Plan, however. Instead, Plan implementation relies on stakeholder support, continued investment in existing programs, infrastructure such as the Idaho Health Data Exchange, and purchasing power. The state plans to incentivize providers to participate voluntarily by paying them incrementally as they meet various national accreditation standards and PCMH milestones. The state also proposes to use its Medicaid purchasing power as a policy lever to help integrate behavioral health and social services with primary care.

The Plan aspires to improve access to care in rural areas and enhance care coordination and integration of behavioral health services with medical services—projecting that 80 percent of residents will have access to a recognized PCMH by 2019.

11.3.1 Models and Strategies

The centerpiece of the Plan is to develop and implement multi-payer PCMHs statewide for all patients. The current pilot of 36 practices only serves patients with chronic or complex conditions. Regional collaboratives would work locally to help practices obtain national PCMH recognition. The Idaho Healthcare Coalition would oversee the Plan and coordinate the regional collaboratives. Idaho has detailed a phased-in payment scheme to incentivize PCPs to participate. The Plan also includes workforce initiatives to make the most efficient use of Idaho’s existing human resources, in part through the innovative idea of creating virtual PCMHs that rely on telehealth, as well as to recruit and retain additional health care personnel of all types—particularly PCPs, behavioral health providers, nurses, and providers willing to work in rural areas. Lastly, the Plan would expand the role of the Idaho Health Data Exchange to

increase health IT capacity and create new public reporting measures to monitor and improve quality. *Appendix Table 11A-1* describes all models and strategies included in the Idaho Plan, initiatives on which they are built, populations they address, and supporting policy levers and entities.

PCMH model. Under the Plan, newly developed and pilot PCMHs would integrate behavioral health services, social and economic services, and wellness and health promotion into primary care. When a patient enters the system, the PCMH would conduct a comprehensive needs assessment, document individual needs planning, develop communication and monitoring tools, and facilitate access to all necessary services. PCMHs would be part of a larger medical neighborhood supporting patient-centered, integrated, coordinated care at the grassroots level across Idaho. The neighborhood would integrate the PCMH with other health and nonhealth entities—including local public health departments, behavioral health services, specialists, hospitals, schools, and social and community supports (such as transportation, housing, childcare, and food services). The Idaho Healthcare Coalition would identify several national PCMH recognition organizations, and PCMHs would choose which standards they would like to meet. The Coalition would also identify minimum operational and staffing requirements for the PCMHs. By meeting those minimum standards, practices could become state-recognized PCMHs (and begin receiving some PCMH incentive payments) before obtaining national recognition.

Several providers involved in the Plan development process stated that there was some debate about PCMHs being the key element in the Plan and how the payment system would work. For example, providers suggested that payers were concerned about getting a return on investment, paying a per member per month (PMPM) fee for all patients rather than just chronically ill or high-utilizer patients, and identifying to whom to attribute a PMPM fee for patients who had not seen a PCP recently. Also according to some providers, hospitals were nervous about the risks associated with having fewer hospitalizations or emergency room (ER) visits as a result of the PCMH model. However, after talking through the benefits of a PCMH and displaying evidence-based data, stakeholders reached consensus on using this model and payment scheme. The Plan proposes that with a Round 2 Model Test award, and once Idaho has received its ICM SPA, all regions in the state would begin implementing the PCMH model for all patients.

To help practices—especially those that are small, rural, and under resourced—develop into PCMHs, Idaho proposes creating seven regional collaboratives, aligned with the Department of Health and Welfare’s regional offices. Regional collaboratives would be built around a hospital system, a public health district, or a collection of rural providers. Stakeholders emphasized that the collaboratives should be independent of government. Collaboratives would respond to local innovation and build up organically; their structure would allow for geographic

differences in population health needs and delivery system capacities to be taken into account. Collaboratives would provide support for training, data analytics and collection, quality metrics, and integrating practices into the larger medical neighborhood, as well as undertake some public health strategies (see below). The Coalition would establish, staff, and finance the regional collaboratives within the first year of the test period, if Idaho receives a Round 2 Model Test award.

The Coalition would support the regional collaboratives in guiding practice transformation to PCMHs, creating some uniformity among the seven regional collaboratives while allowing for local flexibility. The Coalition would have accountability for the Plan meeting its goals if Round 2 funding is received. Specifically, the Coalition would measure and improve population health, establish a behavioral health committee to create screening and assessment tools for PCMHs, provide training to PCMHs to support physical and behavioral health integration, and work with payers to facilitate payment methodology alignment.

Payment model. Idaho plans to implement a payment system for participating practices that not only includes a PMPM fee to pay for the ongoing costs of serving as a PCMH; it also includes start-up funding, incentivizes practices to seek higher levels of PCMH recognition, and rewards practices for meeting quality metrics and savings goals. Idaho plans to phase in this payment methodology individually as each practice's capabilities grow. In Phase 1, practices would receive start-up and accreditation payments provided by the Idaho Healthcare Coalition from Round 2 Model Test funds. In Phase 2, practices would receive PMPM fees from payers for care coordination. These payments would be phased in based on patient complexity (i.e., practices would first receive PMPM fees for patients with complex conditions who require immediate care coordination). Phase 3 would introduce quality incentive payments for adhering to evidence-based practices and reporting, paid by the participating payers. In Phase 4, shared savings payments would begin for meeting cost-savings targets. There is still uncertainty as to how the savings would be returned to the system. Phase 5 presents a value-based payment methodology for primary care and behavioral health. In Phase 6, the shared savings model would expand for more complex clients, as PCMHs reach higher accreditation. Those PCMHs that already have higher level recognition would begin receiving PMPM fees immediately. Idaho's proposed payment model is a unique combination of strategies already in place in other states, according to interviewees, along with some newer strategies, such as phased-in payments based on the capacity of individual practices.

Workforce development. The Plan is designed to maximize the ability of medical personnel to work to the top of their licensure and to recruit more providers into the state. Idaho has proposed two unique innovations to help overcome provider shortages, particularly in rural areas. First, Idaho would implement virtual PCMHs, relying on telehealth capabilities, in which the health care team could be staffed across multiple entities in the region. This model would

maximize the existing workforce, as human resources would be shared across PCMHs in the medical neighborhood. Second, the model would develop the use of community health workers (CHWs) and community emergency medical services (EMS) personnel to be an integral part of the PCMH team. CHWs would assist in numerous ways, including providing clinical services, performing health education activities, or supporting primary care coordination for patients with chronic conditions. EMS personnel would function outside their typical emergency role and help with activities such as in-home follow-ups and reduction in ER use.

In addition, the Plan puts forward several methods to recruit and retain health professionals. These strategies include funding medical residency programs, increasing medical education slots at schools with training in rural health care, targeting students who are interested in working in Idaho for admission to those slots, and funding medical school scholarships for Idaho students and requiring them to practice in the state for a certain period. The Idaho Health Professions Education Council has been added to the Idaho Healthcare Coalition and would advise the Coalition on workforce issues.

Health IT and enhanced data analysis. The Plan proposes expanding the Idaho Health Data Exchange to integrate payer, clinical, and patient data. The goal is for patients to be able to see and use their own data, providers to have updated data and help improve population health, and data to be used for reporting quality metrics. As one stakeholder said of the health IT plan: “When you marry clinical results to claims data and involve patient engagement in the mix, that’s the trifecta that can produce a lot of value in improving the health care system.” The Idaho Health Data Exchange relies on commercial payers remaining engaged and contributing their claims data, and is considering developing a universal patient portal to promote patient engagement. Much of the Plan’s proposed health IT activities are preliminary, to be fleshed out by the Coalition, and would require Round 2 Model Test funds. In the first few years of the test implementation period, the Coalition would contract with a vendor to establish statewide baselines and aggregate the data. One option going forward is that once the Health Data Exchange has established an infrastructure that allows for the interoperability of claims, clinical, and patient data, the state would provide the analytic support to the Coalition to facilitate data management and population health management functions. By the end of the 5-year project period, Idaho aims to have every PCMH using health IT to support care coordination.

Public reporting. As part of the Plan development, the Steering Committee created Idaho’s Initial Performance Measure Catalog—a series of standardized performance metrics to be used across all payers and providers. Metrics represent the areas in Idaho with the most need for improvement—including depression screening, tobacco use and cessation, asthma ER visits, low birth weight rates, childhood immunizations, and access to care. In Year 1 of the Round 2 Model Test grant, the Coalition would develop a baseline for each measure. In Year 2, the Coalition would pick four measures for all PCMHs to report. In Year 3, the regional

collaboratives would identify additional measures to be reported by PCMHs that are most locally appropriate. In addition to these quality metrics, payers would be allowed to require additional metrics of their own.

Public health strategies. In addition to their work supporting PCMHs, regional collaboratives would leverage local resources and expertise (including public health districts and critical access hospitals) to conduct local health needs assessments. Using the results of those assessments, they would work with community partners to design and implement wellness and quality improvement initiatives.

11.3.2 Policy Levers

The Plan relies on voluntary stakeholder action, purchasing power, state policy alignment, obtaining a new Medicaid SPA, continued support for existing initiatives, and the SIM Initiative Round 2 funding. This section reviews the key policy levers proposed in the Idaho Plan; [Appendix Table 11A-1](#) includes all policy levers discussed in the Plan.

As the draft Plan notes: “Idaho’s model is a grassroots effort that builds collaboration and momentum for change rather than depending on mandates and legislative action.” The payers’ and providers’ engagement in the Plan depends on their genuine support and cooperation. However, Idaho also plans to incentivize providers to participate in the Plan through the previously described phased-in payment methodology. The state would use its purchasing power through Medicaid to join primary care, public health, behavioral health, long-term services and supports, and social services to support coordination within the PCMHs and across medical neighborhoods.

The state plans to use its existing Section 2703 health home SPA and would also submit an ICM SPA for Medicaid and CHIP participation in the PCMHs. Idaho would make any necessary modifications to its existing Title XIX (Medicaid) and Title XXI (CHIP) state plans. Rather than using policy levers to create new programs, Idaho plans to leverage existing initiatives—such as the Idaho Medical Home Collaborative pilot and the Idaho Behavioral Health Partnership. Round 2 Model Test funds are a crucial policy lever for Idaho. The money would be used to help fund the Idaho Healthcare Coalition and regional collaboratives, as well as to give practices start-up and PCMH recognition funding. The workforce recruitment plans recommend advocating for additional state funding for medical education or loan repayment programs. The Plan does not identify specific policy levers to develop health IT. All proposed activities are merely “potential next steps,” and Idaho plans to further investigate the Health Data Exchange’s current capabilities and challenges in Year 1 of the test phase through a Coalition-led stakeholder process.

During the 2014 Idaho Legislative session, two concurrent resolutions were passed (HCR 46 and HCR 49), directing the Idaho Department of Health and Welfare to undertake activities related to plans outlined in the Idaho Plan. HCR 46 directs the Department of Health and Welfare to convene a council to coordinate development of a comprehensive plan for telehealth in Idaho and references this activity as a Plan component. HCR 49 directs the Department of Health and Welfare to establish an advisory committee to investigate creation of a hospital discharge data base and comprehensive system of healthcare data, also referencing the Plan. These concurrent resolutions reflect the support of the Idaho legislature for specific activities detailed in the Plan and will serve as policy levers going forward.

Stakeholders considered several policy levers not included in the Plan (and thus not included in *Appendix Table 11A-1*). First, they contemplated requiring PCMHs to use EHRs but preferred to help foster EHR use rather than mandate it. Second, they discussed legislation that would require providers to accept patients from all insurers but felt this would disadvantage providers. Third, they considered a policy mandating that major payers of fully insured health benefits participate in the model but agreed that payers should work collaboratively rather than be required to participate by legislation. Fourth, they considered antitrust legislation but decided it was unnecessary.

11.3.3 Intended Impact of the Plan

The Plan aims to give 80 percent of residents access to a PCMH by 2019. In expanding PCMHs to all patients in Idaho, the Plan would affect a majority of the population, focusing on improving health outcomes as well as prevention and wellness for the entire population. The Plan incorporates the integration of behavioral health into primary care, an identified challenge in the state. The Plan carefully considers the needs of rural populations. As one stakeholder put it: “The rural populations spurred us on....Why should someone who lives in rural Idaho get a lower standard of care than someone in Boise?” Lastly, some attention was given to the six federally recognized tribes in Idaho; the Plan strives to connect the PCMHs with the Indian Health Service.

11.3.4 Proposed Next Steps

The Idaho Healthcare Coalition would guide Idaho’s Plan, as noted. Legislators and other stakeholders involved in the Model Design process encouraged the Steering Committee to create this neutral nonprofit to govern the initiative, so it could respond to both public and private sector needs and concerns. However, the Idaho Attorney General reviewed the Plan’s proposed structure and advised the state and stakeholders that anti-trust concerns would require that the Idaho Healthcare Coalition, at least initially, be managed within state government. The Governor’s executive order establishing the Idaho Healthcare Coalition placed it under the management of the Department of Health and Welfare. The Governor is to make appointments to the new group based on recommendations from the SIM Initiative Steering Committee. The

newly established Idaho Healthcare Coalition would then make recommendations to the Department of Health and Welfare regarding the staffing and budget to support the Plan. These activities would occur before the test period begins. The Coalition would partner with Idaho's Health Quality Planning Commission (established by the 2007 legislature), which will have membership in the Coalition. Money from the Round 2 Model Test award would be used to fund the Coalition initially. Sustainability of the Idaho Healthcare Coalition and Regional Collaboratives will be funded through support from payers and PCMH fees if the new entities demonstrate value following Plan implementation. There was some contentiousness among stakeholders about using a significant portion of test funds to finance the oversight infrastructure, rather than using the money solely to help practices transform to a PCMH.

If Idaho does not receive Round 2 Model Test funds, it intends to implement this model in a limited manner through a small expansion of the existing Collaborative pilot, in both number of participating practices and populations covered. After the end of Phase 1 of this pilot (January 2015), Idaho would evaluate whether (1) the 36 pilot PCMHs can support expansion beyond the chronically ill patient population and (2) the Collaborative can support additional PCMHs.

11.4 Discussion

Idaho has a core group of stakeholders who have worked together on previous initiatives, which helped align thinking around key strategies incorporated into the Plan. By choosing to continue down the same path, the state was able to enlist informed and engaged stakeholders to continue developing their shared vision. Support from political leaders, the potential for achieving change, and good leadership of the planning structure enabled the state to engage other key health care stakeholders in the process. Stakeholders were more supportive of using financial incentives and voluntary cooperation than other policy levers. Thus, Idaho's choice of strategies, efforts to build support among health care stakeholders across the state, and active engagement of payers are all specified as helping implement the Plan. Lack of funding is the biggest barrier; Round 2 Model Test funds are seen as crucial to statewide implementation of PCMHs.

11.4.1 Critical Factors Shaping the Plan

Critical factors in developing the Plan were reported to include Idaho's decision to build on previous medical home initiatives, political support for using voluntary action to implement the Plan, and the engagement of key stakeholders, especially physicians and payers. Because the initiative was organized to advance the PCMH model in Idaho, PCPs were especially interested in the outcome, and were well represented in the process. Their level of participation was cited as a factor in decisions about models and strategies. The state's existing multi-payer Idaho Medical Home Collaborative PCMH pilot, launched in January 2013, was also cited as an important factor in shaping the Plan. Key stakeholders involved in planning the pilot (including

payers) had already agreed to support the PCMH model, and recognized the need for more resources to support practice transformation—especially in rural areas served by small practices. Legislators liked the proposed structure because it would accommodate regional differences.

Commercial insurers yielded on several issues important to other stakeholders. One was the financing to launch and maintain the PCMH support infrastructure, including the state-level Idaho Healthcare Coalition and regional collaboratives. Payers recognized the need but expressed reluctance to fund this infrastructure. This issue was resolved by a recommendation to fund the network infrastructure initially (during the practice transformation phase) with funds from the Round 2 Model Test award. As the PCMHs develop, they would support the Coalition and regional collaboratives through dues payments from their PMPM payments. On the issue of sharing data, payers seem to have been persuaded that data sharing is critical for population health management. These issues will likely require more discussion, but stakeholders seem committed to finding enough agreement to move forward.

With regard to policy levers, stakeholders opted for voluntary participation and use of incentives, rather than regulations and mandates. They sought to minimize new policy levers, particularly mandates—considering and rejecting a requirement to adopt EHRs and also rejecting a mandate that insurers participate in the PCMH program. To authorize Medicaid and CHIP participation, they plan to use existing Medicaid authorities to authorize Medicaid PMPM payments to PCMHs, and an ICM SPA. State authorization for a collaborative effort has come in the form of an executive order.

11.4.2 Lessons Learned

Several lessons were gleaned from Idaho’s experience in the SIM Initiative:

- **The potential for change brought key stakeholders to the table.** Two key factors that were said to bring some major stakeholders into the process were: (1) sponsorship by the executive branch and participation of key legislators, and (2) the prospect of SIM Round 2 Model Test funding, which made broad implementation seem feasible.
- **Good leadership helped engage stakeholders in the process.** The chair of the stakeholder committee and a state official used private meetings and calls to stakeholders to open lines of communication and identify issues. This step revealed some issues that stakeholders had been reluctant to raise themselves in larger meetings. The Steering Committee chair was praised by multiple stakeholders for effective leadership, including keeping the discussion focused without seeming prescriptive.
- **The short time frame was challenging but helped bring planning to a conclusion.** Stakeholders found the short time frame for preparing the Plan to be challenging, but

helpful in instilling a sense of urgency. As one said: “My experience is that if we leave projects with unlimited time, we typically don’t come to a conclusion. But with a set time frame, it’s sometimes a little uncomfortable, but at least you have an end line.”

11.4.3 Potential for Implementation

The strategies selected by Idaho are well supported by evidence, according to stakeholders, and implementation is seen as posing minimal risks to stakeholders. The state’s choice of strategies and process of building a broad base of support provide a strong foundation for implementation. Idaho stakeholders recognized that they were not only developing the Plan, but also building relationships and consensus around key strategies. A provider said that stakeholders had good relationships at the beginning of the process, and “building something together” helped foster even stronger relationships.

Some stakeholders expressed concern that commercial insurers were resisting design features supported by other stakeholders—such as sharing claims data, adopting payment reform, and providing financial support for the Coalition and regional collaboratives. However, an insurer commented that while insurers might appear to be resisting, they were actually debating *how* to implement a concept they supported. As noted above, insurers and other stakeholders seem committed to finding enough agreement to move forward. Insurers’ willingness to engage and negotiate with other stakeholders is seen as a strength for Idaho, and a good indicator of the potential for multi-payer implementation.

Lack of external funding, as noted, appears to be the biggest potential barrier to implementation. A key goal is to expand the PCMH model to rural areas served by small practices with one to three clinicians. There was wide agreement that small practices cannot afford to transform without practice support, which will require external funding. Stakeholders had mixed views about the feasibility of implementing the Plan without additional SIM funding. While stakeholders are convinced they have strong momentum and determination to continue, they recognize that they have very limited resources, and progress would be slow. Although it has developed a Plan with strong support, stakeholders are agreed that Idaho is unlikely to achieve statewide health care delivery and payment system transformation without Round 2 Model Test funds.

11.4.4 Applicability to Other States

An unusual feature of the Plan is the ability to proceed with minimal use of policy levers. State officials believe the degree of consensus around the Plan will satisfy the Governor’s Office and legislators, which has resulted in an executive order. If the Plan is successfully implemented, it could provide a good example of the adaptability of North Carolina’s PCMH model to a small, Western state that favors limited government solutions. In addition, use of

virtual PCMHs through telehealth, CHWs, and EMS personnel would add to states' knowledge of how to effectively augment the traditional PCP workforce.

11.4.5 Limitations of This Evaluation

The evaluation team was unable to interview a consumer representative, but was able to gauge consumer views from the focus group reports. Otherwise, the team had good access to documents, and state officials and stakeholders were available for interviews. The state has continued to refine the Plan in early 2014. We have reflected some of these adjustments in this chapter. However, stakeholder interviews were conducted before those adjustments were made, so we do not have information about how stakeholders view these changes.

11.5 References

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Appendix Table 11A-1. Models and strategies proposed in the Idaho Health Care Innovation Plan

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands (if any) | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|--|---|--------------------------------|--|--|
| <p>PCMH model</p> <p>Develop statewide PCMHs for all patients, supported by RCs (7 regional entities will support PCMH implementation among practices)</p> <p>RCs will train PCMHs and support physical/behavioral health integration</p> <p>RCs will support PCMH training, data analytics/collection, quality metrics, and medical neighborhood integration</p> <p>IHC and the RCs will create medical neighborhoods to integrate the PCMH with other health and nonhealth entities (housing, food, transportation, childcare, education, employment, jails) within the community and support coordination at a grassroots level</p> <p>Develop “virtual” PCMHs in which shared staff on the PCMH team use telehealth</p> | <p>Idaho Medical Home Collaborative Pilot for patients with chronic or complex conditions (Medicaid support is authorized by a health home SPA)</p> <p>Safety Net Medical Home Initiative, supported transformation of 13 safety net clinics into PCMHs</p> | <p>General population</p> | <p>Existing</p> <ul style="list-style-type: none"> *Health Home SPA *Executive Order establishing the IHC within IDHW <p>Proposed executive branch action</p> <ul style="list-style-type: none"> *Apply for and win Round 2 Model Test award *Submit ICM SPA *Modify existing Title XIX (Medicaid) and Title XXI (CHIP) state plans <p>Proposed state regulation</p> <ul style="list-style-type: none"> *Medicaid purchasing power to integrate care across medical neighborhoods and align policies governing multiple state programs <p>State facilitation of system change</p> <ul style="list-style-type: none"> *Payer alignment with provider incentive program *Primary care provider participation <p>Nonhealth entities are willing to collaborate with the PCMHs and RCs</p> <p>None identified for medical neighborhood model</p> | <p>IDHW, IHC, RCs, medical neighborhoods, participating providers, Medicaid, PacificSource, Regence Blue Shield of Idaho, Blue Cross of Idaho, nonhealth care entities</p> |
| <p>Payment model</p> <p>Phased-in payment scheme to incentivize providers to participate in the PCMH model</p> | <p>None</p> | <p>Participating providers</p> | <p>Proposed executive branch action</p> <ul style="list-style-type: none"> *Implement payment incentive scheme in Medicaid <p>State facilitation of system change</p> <ul style="list-style-type: none"> *Implement payment incentive scheme in payer-provider contracts | <p>Medicaid, PacificSource, Regence Blue Shield of Idaho, Blue Cross of Idaho, IHC, RCs</p> |

(continued)

Appendix Table 11A-1. Models and strategies proposed in the Idaho Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands (if any) | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|---|--|-----------------------|--|--|
| <p>Workforce development</p> <p>Develop use of CHWs and EMS personnel in the PCMHs, especially in rural areas with workforce shortages</p> <p>Recruit and retain health workforce personnel of all types, particularly physicians, nurses, and behavioral health providers in the state with an emphasis on rural areas</p> <p>Use telehealth to create virtual PCMHs, maximizing the efficiency of existing workforce personnel</p> | <p>Ada County (Idaho) Community Paramedic Program</p> <p>EMS/CHW program in Bonner County, Idaho</p> | <p>N/A</p> | <p>Existing</p> <p>*Legislative resolution HCR 46, directing IDHW to convene a council tasked with developing a comprehensive telehealth plan in Idaho</p> <p>Proposed state regulation</p> <p>None identified for CHW and EMS strategy</p> <p>Proposed executive branch actions</p> <p>*Fund residency programs</p> <p>*Fund medical school scholarships for students who will return to Idaho to practice</p> <p>*Fund loan repayment programs</p> <p>Increase financial assistance for students in all health education programs</p> <p>*Update higher education agreements with Idaho nursing education institutions to increase access to advanced nursing degrees</p> <p>State facilitation of system change</p> <p>*IHC will encourage CHW/EMS development</p> <p>*IHC will partner with local experts to train CHWs and EMS personnel</p> <p>*IHC will work with Idaho’s Telehealth Task Force to expand telehealth capacity</p> <p>*IHC will further develop the virtual PCMH model through stakeholder input</p> | <p>IDHW, IHC, Health Professions Education Council, Area Health Education Center</p> |

(continued)

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Appendix Table 11A-1. Models and strategies proposed in the Idaho Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands (if any) | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|---|--|------------------------------------|--|---|
| Health IT and enhanced data analysis IHC will partner with the IHDE to assess its capabilities and weaknesses Expand IHDE to integrate claims, clinical, and patient data for quality reporting and to improve population health | IHDE | N/A | Existing * Legislative resolution HCR 49, directing IDHW to establish an advisory committee to investigate the creation of a hospital discharge data base and comprehensive system of healthcare data State facilitation of system change IHC will meet with stakeholders to further develop the health IT aspects of the Plan IHC will promote EHR adoption | IHDE, IHC, RCs, providers, payers |
| Public reporting Idaho Initial Performance Measure Catalog of quality measures that reflect the areas of greatest need for improvement | None | Participating providers and payers | State facilitation of system change *IHC will select quality measures for reporting *Providers that choose to participate in the PCMH rollout will report quality metrics from the Catalog | IHDE, participating providers, participating payers, RCs, IHC |
| Public health strategies RCs to conduct local health needs assessments and implement wellness and quality improvement initiatives through PCMHs focusing on population health | None | General population | State facilitation of system change Funding for RCs Local participation in RC initiatives | RCs, local entities |

¹Policy levers include Medicaid waivers; federal grants (including Round 2 SIM award); state laws; state regulations; state investments (e.g., in public health programming); foundation grants; employer-led coalitions to drive change among providers, purchasers, or plans; state government-led coalitions, task forces, or commissions to drive voluntary change among providers, purchasers, or plans; state purchasing contracts; and state-level (Governor-initiated) executive policy directives.

Abbreviations: CHW = community health worker, EHR = electronic health record, EMS = emergency medical services, health IT = health information technology, ICM = integrated care model, IDHW = Idaho Department of Health and Welfare, IHC = Idaho Healthcare Coalition, IHDE = Idaho Health Data Exchange, N/A = not applicable, PCMH = patient-centered medical home, RC = regional collaborative, SPA = state plan amendment.

12. Illinois

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To develop the state's Health Care Innovation Plan (the Plan), Illinois established the Provider-Plan-Payer-Population Alliance for Health (Alliance)—a new group of state agency and private sector stakeholders convened by the Governor's Office and supported by its contractor, Health Management Associates (HMA). Medicaid and the providers and health plans that serve Medicaid enrollees were most well represented, in part because a 2011 Medicaid reform state law required a shift towards purchasing coordinated care by 2015, and the Alliance provided a forum in which affected providers and Medicaid could discuss how that change would be implemented. The core management team for the Alliance, which comprised representatives from the Governor's Office, HMA, and Medicaid, engaged the Illinois Department of Public Health (IDPH) to lead a population health task force, which was added after the planning process began and was significant in expanding Plan content. Substantial effort was put into engaging a wide range of stakeholders to serve on the Alliance's Steering Committee.

The Plan outlines a vision for improving the state health care system and reducing its cost, in the context of the state's relatively low per capita supply of nonphysician providers and a diffuse health care market. The Plan proposes implementing pilots of a health care delivery system and payment model that adapts and extends the accountable care organization (ACO) concept, as well as proposes changes to the workforce and enhanced data systems to support that model and a parallel set of strategies to enhance public health infrastructure. While the ACO-like model is designed for implementation by Medicaid initially, it is intended as a model for the commercial and Medicare sector by 2016; other strategies are planned to impact at least 80 percent of the state population, although no specific timeframe is given.

Two major policy levers, the 2011 Medicaid reform state law noted above and a 2013 state law that enabled Medicaid to contract with new accountable care entities (ACEs), are already in place to help achieve the planned Medicaid reforms. In addition, the state plans to pursue a Medicaid section 1115 waiver. Other than that, the Plan proposes a wide array of state legislative and regulatory policy mechanisms, and state facilitation of change in the private sector.

12.1 Context for Health Care Innovation

The Illinois Governor's Office and its contractor, HMA, convened the Alliance in the context of: (1) 2011 Medicaid reform legislation that requires transition away from a mainly fee-for-service payment model by 2015, (2) a new model of care developing within the Cook County

Health and Hospital System (CCHHS), (3) a low ratio of nonphysician providers to population relative to other states, and (4) a state health care market with many nonaffiliated providers and employer-specific insurance products. This context influenced the stakeholders involved in developing the Plan as well as the Plan's content.

In January 2011, Governor Pat Quinn signed Medicaid reform into law under Public Act 96-1501, according to which Illinois must enroll at least half of its Medicaid population into coordinated care by January 1, 2015 (215 ILCS 170/56). Currently, most Medicaid enrollees participate in Illinois Health Connect, a primary care case management program in Illinois, which does not meet the law's criteria for coordinated care. To meet the expectations of this state law, the Medicaid agency, Healthcare and Family Services, selected five care coordination entities (CCEs) and one managed care coordination network in October 2012 to provide integrated services for beneficiaries who are aged and/or with disabilities by fall 2013 (Alliance, 2013). A new 2013 law (State of Illinois, Public Act 098-0104) resulted in a similar open solicitation for ACEs for families with children and newly eligible individuals. Both of these programs complement existing managed care organizations (MCOs) that serve certain Medicaid subpopulations, such as dually eligible enrollees in the Integrated Care Program.

In 2012, the Medicaid reform law was amended to permit the CCHHS system to expand Medicaid eligibility early, using a Medicaid section 1115 waiver, to individuals who would otherwise become eligible under the Patient Protection and Affordable Care Act (ACA) in 2014 (Alliance, 2013). CCHHS began enrollment in CountyCare on January 1, 2013. CountyCare beneficiaries receive services from CCHHS, which coordinates care as a provider and a health plan. As a result, CCHHS has gained more experience with serving vulnerable populations with complex needs.

Stakeholders involved in the Alliance expressed concerns that Medicaid expansion under the ACA would exacerbate perceived deficits in the current Illinois health care workforce. For example, Illinois has shortages in rural and safety net providers (State of Illinois, 2012a). Few mechanisms are in place to address the shortage; Illinois does not have a Medicaid graduate medical education (GME) program, nor a state health professionals loan repayment program. Additionally, Illinois has a low ratio of nonphysician providers to population compared to national averages (SHADAC, 2012), which the Plan attributes to Illinois law limiting the scope of practice for nurses and other nonphysician providers, who may not diagnose or treat patients without physician oversight. An effort to introduce new legislation that would allow advanced practice nurses to practice without a written agreement with a physician did not pass in the state legislature during the 2013 session ("Illinois doctors block," 2013). Furthermore, Illinois does not have standard training or a formal certification process for community health workers (CHWs), although one college in Chicago does have a pilot program to develop such a curriculum (Alliance, 2013).

Finally, payer and health plan stakeholders noted that insurance carriers in the state have many individual contracts with employers. These contracts: (1) have resulted in multiple product designs in which providers operate, and (2) hinder insurers from making changes in provider networks and payment models that would encourage greater care coordination.

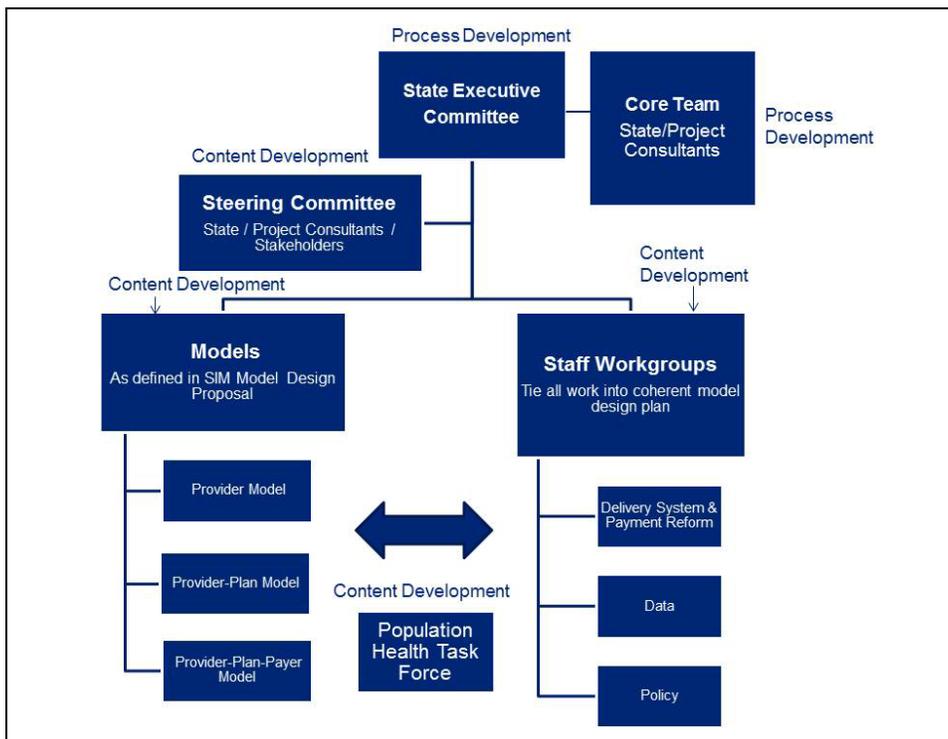
12.2 Planning Infrastructure and Process

Stakeholders observed several defining characteristics of the Alliance’s infrastructure and planning process. First, the Governor’s Office managed the process to develop the Plan and reportedly tried to ensure it reflected all perspectives raised during the Alliance. Second, HMA provided critical staff support to enable broad stakeholder engagement that state officials otherwise would not have the capacity to do, such as communicating across multiple entities and the public, facilitating meetings, and preparing documents between meetings. Third, the planning infrastructure—which started with six work groups that exchanged ideas and then sent recommendations to a larger Steering Committee of stakeholders for feedback—evolved over time to eventually include a Population Health Task Force led by the IDPH. Although public health advocates and provider groups noted some disappointment in the process for engaging consumers and the public, and identified some stakeholders as missing from the planning process, they saw these limitations as creating potential challenges for Plan implementation rather than significantly detracting from the content of the Plan itself.

Governance and management. The state’s executive branch heavily committed its staff to support the Alliance. A state Executive Committee, comprising Department Directors of relevant state agencies, provided executive oversight and coordination for the Alliance (see [Figure 12-1](#)). The Governor’s Office lead staff for the Alliance managed the Plan development process through the Core Team, which met weekly. The Core Team included the Governor’s Office (including the Office of Health IT [health information technology]), Medicaid staff, and HMA. The Model Design award partially funded the salary of only one state staff member (State of Illinois, 2012b, p.1). State agency staff participated in all the other work groups as in-kind state staff support. Other than in-kind support in the form of salaries for several employees dedicated to the Model Design process full-time, the state did not allocate additional funding.

Stakeholder engagement. To solicit more active involvement of other stakeholders, the Governor’s Office directed HMA staff, rather than state officials, to lead the work group and other stakeholder meetings. The Governor’s Office and HMA began the Model Design process by conducting outreach to stakeholders before the initial kick-off of the Alliance. For example, HMA staff held key informant interviews and small group briefings with provider organizations, payers, public health officials, and other stakeholders (Alliance, 2013). These one-on-one or small group meetings yielded ideas that became the starting point for discussions at Alliance meetings.

Figure 12-1. Provider-Plan-Payer-Population Alliance for Health planning infrastructure



Source: Alliance, 2013

The Governor’s Office also invited a broad range of stakeholders to participate on the Alliance Steering Committee, a new stakeholder body that served as the clearinghouse for ideas and recommendations. Nearly 100 individuals participated from individual provider organizations—including the University of Illinois Hospital and Health Sciences System, the hospital association and health care professional societies, Blue Cross Blue Shield of Illinois and several Medicaid MCOs, several local health departments (LHDs), some consumer and public health advocacy groups, community-based organizations, and business groups. Steering Committee and work group meetings were held in Chicago and Springfield (video conferencing connected participants in these locations), but included representation from stakeholders across the state. HMA staff led the Steering Committee meetings, which were held four times during the Plan development process (Alliance, 2013). The Steering Committee reviewed ideas generated by the work groups (see below), Core Team staff, the state Executive Committee, and Steering Committee discussion informed further development of ideas in the work groups, in an iterative process.

In addition, the Alliance used the existing Health Care Reform Implementation Council, convened in June 2010 by executive order to advise Illinois on ACA implementation, as one of the key existing stakeholder groups at which to present the Alliance’s progress. Members of the

Council include many Department Directors, and the Council is chaired by the Governor's senior health policy advisor, who led the Alliance. Council meetings are subject to open meetings laws and well attended by various stakeholders and the public; meeting notes are available online.

As noted by other stakeholders involved in the Alliance, some groups—including the nursing home trade association and providers serving people with disabilities—were either absent from or less vocal during the Plan development process; although invited, some of these groups chose not to participate or were perceived by stakeholders to be present but not active in the process. The Alliance leadership invited board presidents or other provider representatives (rather than staff) from the Illinois State Medical Society, Illinois Academy of Family Practice, and the state Academy of Pediatrics, to achieve provider participation in the process. However, one stakeholder observed that most participating providers were part of larger or more integrated care networks.

Most stakeholders of all types reported that they were given adequate opportunity for comment and that the iterations of recommendation statements and Plan content reflected the degree of agreement or disagreement across stakeholders on each topic. Some suggested that HMA staff tightly controlled the development of consensus statements and the content of the Plan, but they also saw this as a likely factor in achieving a coherent end product. Stakeholders of all types saw HMA as accurately and fairly incorporating comments from all parties.

Work groups. The Governor's Office limited participation in the initial six work groups to representatives of providers and health plans that serve the Medicaid population, and generally only one state staff member and one HMA consultant. These work groups developed the recommendations and ideas the Steering Committee vetted. Three model work groups generated details of different delivery system and payment models, and three supporting work groups synthesized ideas from across models. The model work groups included the Provider Model (focused on how to develop provider-led integrated delivery systems [IDSs]), the Provider-Plan Model (focused on aligning health plan payment models with new delivery system models), and the Provider-Plan-Payer Model (focused on aligning provider, health plan, and payer roles, as within CCHHS). Each model work group selected individuals to represent it on the supporting work groups: (1) Delivery System and Payment Reform, (2) Data, and (3) Policy (Alliance, 2013).

Population health task force. Based on feedback from the IDPH and community stakeholders who advocated for incorporating more of a public health perspective in the Plan, the Governor's Office adjusted the planning process in the early months of the Alliance to add a Population Health Task Force. The IDPH convened this task force, which included stakeholders other than those involved in serving the Medicaid population. The task force proposed new strategies for Steering Committee discussion and potential inclusion in the Plan.

Consumer engagement. The Core Team hosted several town hall meetings and accepted public comments through the Alliance Web site. The Core Team also used the Alliance Web site to post the September and October 2013 versions of the draft Plan, as well as public comments received on the September version. Stakeholders noted that the publicly posted information was helpful in communicating with their constituencies. However, several stakeholders also noted that town hall meetings and Web site posts were not sufficient to involve consumers (including key Medicaid groups, such as persons with disabilities).

12.3 The Illinois Plan

As the centerpiece of the Plan (Alliance, 2013), Illinois would build on current Medicaid initiatives that encourage clinical integration across providers (e.g., CCEs) to develop a delivery system and supporting payment model similar to ACOs. Illinois plans to pilot-test the model with providers that serve populations eligible for Medicaid, dually eligible for Medicaid and Medicare, or uninsured. One main policy lever—the 2011 Medicaid reform law—is already in place to facilitate adoption of this model. The other proposed policy lever is a planned application for a new Medicaid section 1115 waiver. Following the Medicaid pilot test, Illinois proposes to expand it to the commercial population, but the Plan does not identify the policy lever for doing so.

The Plan includes additional strategies to build infrastructure that would support public health, develop the health care and nonhealth care workforce, and enhance data analysis. The policy levers to support these strategies include seeking changes in state law, state regulation, and executive branch activity, and voluntary actions in the public and private sector; the Plan also notes areas in which changes in federal law would assist in implementation of these strategies. These additional strategies are designed, according to the Plan, to affect the health care delivery system for at least 80 percent of the state’s population.

12.3.1 Models and Strategies

The Plan proposes innovations in four main categories: (1) an ACO-like delivery system model, with enhanced features to serve special populations; (2) public health strategies to improve population health; (3) workforce development; and (4) enhanced data analysis. All the innovations considered during the Plan development process fell into these main categories. [Appendix Table 12A-1](#) provides a summary description of the innovations proposed in each category, the initiatives on which they are built, populations they address, and supporting policy levers and entities.

ACO-like model. The Plan envisions a health care system composed of IDSs, each responsible for providing or arranging services across the spectrum of health care (e.g., inpatient, primary care, behavioral health, specialists) for a defined population. Each would have a

governance structure to facilitate performance-based payment to participating providers and monitor a common set of quality metrics. The IDSs would be built around patient-centered medical homes; a care coordinator would be located within every participating primary care practice. The proposed model is similar to an ACO model, in that it would transfer risk for cost and accountability for quality to the IDSs themselves (for differences see below). This model builds on the 2013 Illinois law that created ACEs to act as IDSs for certain Medicaid enrollees (families with children and individuals newly eligible for Medicaid under the ACA) (P.A. 098-0104) and the 2011 Medicaid reform law that enabled development of CCEs (215 ILCS 170/56). The Plan proposes to use the Medicaid ACEs and CCEs in a pilot program to test this model of care in 2014 and 2015, expand it to Medicare and commercial plans in 2016, and to public employees and employer-sponsored groups in 2017.

The proposed model also differs from a standard ACO in several ways. First, the Plan is prescriptive as to the necessary composition of providers within each IDS or with whom the IDS must arrange services. Second, the Plan envisions greater standardization of the format for a patient care plan providers within and across IDSs would use. This care plan, and a uniform risk assessment, would be supported by a common health IT platform to facilitate the transfer of patient information across all providers within an IDS. The platform would build on the infrastructure of the Illinois Health Information Exchange (IL HIE). Third, for populations with specific needs, the IDSs would integrate social service providers and other community agencies with the health care delivery system, and build on the CCEs already in place. Fourth, ACEs would move beyond a shared savings arrangement to prepaid capitation and then full-risk capitation.

Finally, Illinois expects to leverage the development of IDSs to disburse pay-for-performance payments to providers and offer shared savings arrangements in a more uniform manner—regardless of the health plan or payer offering the pay-for-performance program—with respect to both quality metrics used and timing of payments. Although not part of the ACO-like delivery and payment model itself, this pay-for-performance element of the Plan is proposed as a new payment model to facilitate delivery system transformation, initially for Medicaid MCOs, and eventually for health plans in the private sector and Medicare, starting in 2016.

Workforce development. This component of the Plan has four goals. The first is to create new health care worker roles, such as CHWs, community paramedics, and peer mental health counselors; enhance existing roles, such as home care aides; and develop training programs for each, building on existing programs. The second goal is to revise scope of practice regulations to allow nonphysician providers to work at the top of their training and education. The third goal is to increase the primary care, specialty, and behavioral health workforce in underserved communities through a Medicaid GME program and health professionals loan

repayment program. The fourth goal is to offer training opportunities to ensure implementation of team-based care in the IDSs.

Public health strategies. The Plan describes three main public health strategies to address population health improvement. The first is to pilot community health improvements, using the model of asset-based community development (ABCD) already in use in some Chicago neighborhoods, to strengthen communities with a high percentage of low-income, Medicaid-covered residents. The second strategy is a regional hub structure, which would apply LHD staff and IDPH coaches to the development, implementation, and ongoing evaluation of health promotion, wellness, and other population-focused efforts; the state would start with a pilot in one region by 2014 and expand gradually until it is statewide in 2018. The third is coordination between nonprofit hospitals' community health needs assessments (CHNAs) and LHDs—a model already in place in at least one county—and, eventually, shared community health interventions across community providers.

Enhanced data analysis. The Plan proposes building an infrastructure to support a “Learning Health Care System.” This planned infrastructure includes an all-payer claims database (APCD) to capture cost and quality data, as well as real-time clinical data, starting with Medicaid claims and including claims from Medicare by 2017. The planned infrastructure also establishes a state-sponsored Innovation Transformation Resource Center that would work with IDSs, ACEs, and CCEs to share best practices for delivery system transformation. These new entities would function under a new Governor’s Office of Health System Transformation.

12.3.2 Policy Levers

Existing and proposed policy levers for Plan implementation are listed in [Appendix Table 12A-1](#). In some cases, the Plan articulates clear state regulatory and legislative actions needed to implement the envisioned changes in Illinois’s health care system, workforce, and public health infrastructure; in other cases, the Plan assumes that state facilitation of system change will be sufficient to make changes in the private sector. In addition, some policy levers proposed in earlier versions of the Plan were omitted or softened in the final version. This section notes some of the key policy levers considered, rejected, or adopted during the planning process.

Two important policy levers to move Illinois’s health care system towards greater integration are already in place: the 2011 Medicaid reform state law and the 2013 state law that expanded Medicaid coverage and enabled Medicaid to contract with new ACEs. In addition, the Governor’s Office is already pursuing a Medicaid section 1115 waiver, which is the most significant policy lever for implementing several proposed strategies. For example, Illinois anticipates the waiver would provide funding to invest in creation of provider-driven IDSs (CCEs and ACEs)—through data analysis infrastructure, staff training, and administrative

support. The waiver is also described as allowing the state greater flexibility in funding comprehensive services that address the social determinants of health, such as supportive housing, as well as more prevention and wellness-focused services. Payments to providers under the waiver would also shift to more incentive-based and pay-for-performance mechanisms. By combining the services and populations covered by nine existing Medicaid Section 1915(c) Home and Community-Based Services waivers, the state would allow the delivery of long-term supports and services through new provider networks (e.g., MCOs, CCEs, and ACEs). Finally, the new waiver would offer a funding mechanism to facilitate proposed workforce development innovations—such as implementation of the GME program, loan repayment, and other workforce training. The Plan broadly suggests that some funding of new entities and initiatives could come from a waiver, and some from a Round 2 Model Test award.

The Alliance has also identified changes in laws and regulations that Illinois could pursue to support IDSs, workforce development, and enhanced data analysis, regardless of the status of the state's application for a Round 2 Model Test award or Medicaid Section 1115 waiver. For example, changes in state law would be required to facilitate information sharing across providers (e.g., to share HIV/AIDS treatment information and allow laboratories to release information to providers other than the ordering provider), which underpins the functioning of the ACO-like model. The Alliance also proposes to pursue state legislation to enable development of a certification program for CHWs and an APCD. Under the Plan, state agencies would also revise Medicaid regulations that currently allow contracting with only individual providers rather than groups. The Alliance proposes to revise health professionals' scope of practice regulations, as well.

The Plan identifies actions the executive branch could take to implement key components. The Office of Health IT that operates the IL HIE can change policies to create access for nonhealth care providers, which would support greater integration of health care and social services within the CCEs and ACEs. The state's procurement for Medicaid ACEs, which occurred concurrent with Plan development, already required connection to the IL HIE. Changes to rules governing Medicaid payments to mental health providers would support proposed changes to develop the Illinois behavioral health care workforce. The IDPH can change policies to facilitate greater coordination of health planning across LHDs and not-for-profit hospitals, and plans to initiate one regional hub with existing resources in fiscal year 2015. Finally, in January 2014, the Governor established by executive order the new Office of Health Innovation and Transformation, as noted, to oversee implementation of the Plan.

Several policy levers proposed during the Alliance process proved to be controversial, and the final version of the Plan reflects more community consensus around *what* should be done than *how*. For example, stakeholders voiced strong opinions—both for and against—a state mandate that every provider receiving payments from Medicaid directly connect to the IL HIE.

Instead of proposing such a mandate, the Plan says Illinois will “develop a plan to require that all Medicaid providers share patient encounter data with health plans or the state,” either through their regional health information exchanges (HIEs) or the IL HIE. Rather than propose to seek changes in scope of practice laws, the Alliance proposes to: (1) create an advisory board that would coordinate such proposals across all health professions, and (2) revise regulations.

Several parts of the Plan are not to be implemented with specific policy levers per se. For example, the new Governor’s Office of Health Innovation and Transformation is expected to facilitate consensus among commercial payers to align with the delivery system and payment model Illinois proposes to pilot-test with the Medicaid population, and to adopt a common set of quality metrics. Efforts to support workforce development—such as new care roles of peer mental health counselors or community paramedics and enhanced training for home care aides—are being incorporated into the Governor’s proposed fiscal year 2015 budget request. A living wage for health care workers (also proposed in the Plan), is being integrated into general minimum wage increase discussions with the General Assembly (personal communication, March 20, 2014).

Several proposed strategies did not seem to have clear policy levers to ensure their implementation. For example, the Plan is silent on what policies are needed to enforce the proposed delineation of roles and responsibilities across health care and social service providers—and payers—that serve special populations, under the newly proposed models for IDs. There is no description of how the state would fund the pilot of the community-based intervention using the ABCD model. In addition, the Alliance proposes to change federal law to assist with Plan implementation related to exchanging substance abuse treatment, but there is no formal plan to pursue a waiver of those federal laws for Illinois.

12.3.3 Intended Impact of the Plan

Despite the Plan’s initial focus on changing the delivery and payment model for the Medicaid population, most stakeholders agreed that the Plan is designed to reach at least 80 percent of the state’s population. For some, inclusion of the regional hubs to support public health planning and intervention meant that the Plan addresses issues that affect all of Illinois’s population, after its roll-out from one region. One stakeholder surmised that reorganizing the delivery system to improve care coordination for the Medicaid population would help the rest of the population served by the same delivery system.

12.3.4 Proposed Next Steps

The new Governor’s Office of Health Innovation and Transformation was designed to leverage existing state staff to create necessary alignment across state agency health reform efforts, manage continued community engagement, and lead and coordinate implementation of the Plan.

Illinois plans to pursue both a Round 2 Model Test award and a Medicaid section 1115 waiver; but the Governor's Office staff managing the Alliance process has communicated to stakeholders that the state will work to implement as many aspects of the Plan as possible, with or without new funding.

12.4 Discussion

The Medicaid reform law in Illinois created an engaged group of provider and health plan stakeholders and set into motion changes in health care delivery system coordination and integration. The planning structure that evolved under the Alliance enabled an equally motivated group of public health advocates to emphasize the incorporation of important nonhealth care–system factors in determining population health; these advocates expressed optimism that health care providers and state officials heeded this message.

However, whether because of time constraints imposed by the award period of performance, or an unwillingness to alienate stakeholders during the planning process, many stakeholders felt the Plan was short on details about how change would be implemented. This lack of detail led to concerns about its feasibility, particularly with regard to implementation of interventions aimed at improving population health, which had a less defined funding source than other changes. Despite this uncertainty, Illinois succeeded in using the Alliance to rally a diverse set of stakeholders behind a vision for: (1) a health care delivery and payment system model and (2) changes in the health care workforce, enhanced data analysis, and public health, and to make changes within state government through creation of the Governor's Office of Health Innovation and Transformation.

12.4.1 Critical Factors Shaping the Plan

Three critical factors are said to have shaped the Plan: (1) the existing policy and programmatic context, especially with regard to Medicaid; (2) the inclusive and adaptive approach by the Governor's Office to managing the Alliance, which enabled a greater consideration of strategies to improve population health; and (3) use of HMA as a “neutral” facilitator of the process.

The Medicaid reform law provided the motivation to bring health care providers and state agency stakeholders to the Alliance (i.e., providers that formed CCEs, health plans in the Integrated Care Program, CCHHS, or Medicaid). As a result, these stakeholders' experiences of developing existing initiatives, such as development of CCEs and newly forming ACEs, gave individuals involved in the Alliance a common vocabulary with which to discuss a vision for IDSs.

With regard to stakeholder engagement, several stakeholders, mostly from public health fields, noted that the Governor’s Office welcomed them when they asked to participate in the Steering Committee of the Alliance. This openness contributed to the expansion of the Alliance focus to include the Population Health Task Force. This task force is directly responsible for including strategies in the Plan to improve population health through data monitoring and interventions outside the traditional health care system, which had not been contemplated at the time of the SIM application. Changing the Alliance planning infrastructure had the direct result of expanding the focus from IDSs among providers who serve the Medicaid population to meeting overall community health needs—though perhaps not as much as some would have liked, especially stakeholders who see a strong connection between human services, housing, transportation, and health outcomes.

Finally, many stakeholders across all categories praised HMA for acting as a “neutral” party, incorporating feedback raised at work groups, and soliciting one-on-one input from health plans that may have been more candid with them than with a state official. In addition, stakeholders observed greater communication and collaboration across state agencies during this process. They noted that having HMA staff support this process increased coordination at the state level, which otherwise could not happen in an environment where multiple initiatives are competing for state staff time and resources.

12.4.2 Lessons Learned

Illinois’s experience in the SIM Model Design initiative yields several lessons, according to stakeholders.

- **A trade-off may exist between obtaining broad consensus on a plan and providing details on how to implement Plan elements.** The Governor’s Office was successful in building an inclusive and transparent planning process, including a large Steering Committee, which built trust with the stakeholders involved. However, a common theme we heard from health plan and provider stakeholders was that the draft Plan lacked enough detail for them to determine the likelihood it would be implemented, or in some cases, whether their organization would be involved in implementation or would be supportive of all Plan aspects. Thus, the Alliance may have chosen stakeholder inclusion and consensus-building over mapping an explicit path for: (1) how providers would form IDSs, (2) how commercial plans might align with Medicaid in terms of quality measures and payment approaches, or (3) how public health innovations would be funded.
- **The types of stakeholders included in the development process can determine the Plan design.** As noted above, a broad array of stakeholders were involved in the Steering Committee. However, the initial design of the Alliance work groups that reported to the Steering Committee limited discussion of health care delivery system changes to a small number of representatives from health plans and providers

involved in Medicaid, state officials, and HMA consultants. The Population Health Task Force provided an opportunity for other public health stakeholders to contribute additional ideas about the social determinants of health and the role public health and human services could play to improve population health—but only later in the planning process. As a result, some stakeholders expressed concern that policy and funding mechanisms to address social determinants of health are less defined in the Plan than other health care delivery system design elements.

- **The short time frame had both advantages and disadvantages.** Providers, health plans, and public health advocates felt the time frame was too short to gather and synthesize input, produce the Plan, and get the draft Plan into a succinct, digestible format. One stakeholder mentioned that compressing the amount of stakeholder input needed into biweekly work group meetings over a short time period could discourage participation for those that could not balance the intensity of the process with their organization’s other priorities and their individual responsibilities, although other organizations indicated that they purposefully assigned multiple individuals to share responsibility for participating in the Alliance. State agency officials, in contrast, appreciated that it was not a protracted process.

12.4.3 Potential for Implementation

All stakeholders identified potential barriers to implementing the Plan—barriers related to potential lack of resources to implement parts of the Plan, feasibility of the strategies proposed in the Plan, and needed policy changes. In addition, we heard concerns with assumptions made in the Plan that could threaten its implementation in the next few years.

First, with regard to resources, several provider and public health stakeholders noted that the state has limited staff with institutional knowledge of Medicaid policy and time available to dedicate to Plan implementation. They believed additional funding for outside consultants is needed. Moreover, since the funding sources for public health innovations are least well-defined, public health advocates were concerned that the funding sought for changes in the health care delivery system would not extend to investments in community and population health interventions. Finally, at least one provider stakeholder noted that providers will likely need an up-front influx of resources to become an IDS, and that if it is not be available, the transformation envisioned may not occur.

Second, with regard to feasibility, we spoke with representatives from payers, health plans, and providers who were supportive of the Plan in concept, and the delivery system and payment reforms for Medicaid in particular, but who questioned whether providers would share data and use a common health IT platform, which the Alliance envisioned as the foundation for IDSs. They also noted barriers to adopting a common set of quality metrics, especially among health plans that had products in other states. In addition, health plans and purchasers noted that commercial payers’ approach to paying care providers and networks is often determined by

individual contracts with employers, which could only change slowly as those contracts were renegotiated.

Third, several stakeholders noted that a 2014 change in the party holding the Governor's seat could change the Plan's direction. Finally, several stakeholders noted that the provider community caring for the developmentally disabled and other current Medicaid Section 1915(c) Home and Community-Based Services waiver populations may not support the proposals for integrated care networks or the proposed new Medicaid section 1115 waiver, which could be a threat to their service niche.

In addition to the perspectives on implementation offered by stakeholders, we identified two potential threats to implementation in the near-term. First, the Plan cites a prior report in Illinois that indicates providers are reluctant to take on additional risk in a payment arrangement because they do not have a sufficiently sized panel covered by any one health plan to justify investment in changing their structure to support greater risk-sharing. Without greater employer engagement and health plan commitment to move towards payment reform, changes in Medicaid policy may not be a strong enough lever to change the rest of the health care delivery system in Illinois.

Second, the Plan suggests Illinois should pursue changes to federal law to ease the sharing of certain substance abuse treatment information as the policy lever that would enable transformation within the Illinois health care delivery system. This would represent a departure from current federal policy.

12.4.4 Applicability to Other States

None of the models or strategies in the Plan leverages a key characteristic of Illinois that would render it inapplicable to other states, according to stakeholders. However, some issues Illinois seeks to address may not be relevant in other states. For example, some other states already allow greater scope of practice for their nonphysician providers. Similarly, the opportunity to align a health care payer, health plan, provider, and public health department—as is under way in Cook County—may be applicable only in other states with large county health care systems.

12.4.5 Limitations of This Evaluation

All stakeholder interviews were completed prior to submission of the final Plan, so this analysis may not accurately reflect stakeholders' opinions of the final Plan. In addition, two stakeholders, one with a provider perspective and one with a public health advocacy perspective, declined to speak with us.

12.5 References

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Appendix Table 12A-1. Models and strategies proposed in Illinois Health Care Innovation Plan

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|--|---|---|--|--|
| ACO-like model | CCEs | 2014: Medicaid population: seniors (dually eligible), people with disabilities, children and parents | Existing | Medicaid; Health Facilities and Services Review Board; IL HIE; Medicaid-contracted providers; eventually all providers |
| Comprehensive, community-based IDS | Integrated Care Program sites | | *P.A. 96-1501 ("Medicaid reform") signed into law in January 2011 | |
| Multiple pilots in various geographic regions; key features include: | Newly developing ACEs | | *P.A. 098-0104 ("Medicaid Health Benefit Services") enabling ACEs signed into law in August 2013 | |
| Team-based care | Primary care case management: Illinois Health Connect | 2014: Additional integration for specific populations: frail elderly, seriously mentally ill, justice-involved, homeless, HIV-impacted, developmentally disabled, autistic, other special needs | Federal Demonstration award: Medicare-Medicaid Alignment Initiative | |
| Ability to accept and distribute payments and financial incentives to providers | Voluntary managed care in select regions (2 insurer-based MCOs, 1 provider-based managed care coordination network) | | Proposed state legislative actions | |
| Ability to conduct performance evaluation of individual physicians and practices | Medicare-Medicaid Alignment Initiative | | *Remove barriers to sharing HIV/AIDS treatment information across providers | |
| For special populations, define partners broadly; define partners' roles and increase capacity to offer client-directed services | CountyCare (in Cook County) | 2016: Medicare, commercial populations, self-insured populations | *Remove the requirement that restricts delivery of laboratory results to the ordering physician | |
| Implement a consumer-directed model of offering services within a budget based on specific needs | Money Follows the Person | | Pursue state-based health insurance marketplace | |
| Provide technical assistance to entities not in pilot programs | Balancing Incentive Program funds to expand the capacity of community-based services | | Proposed state regulatory actions | |
| | | | *Change policy to allow the Department of Healthcare and Family Services (Medicaid) to contract with groups in addition to individuals | |
| | | | Standardize consent form for sharing health information | |
| | | | Standardize terminology for laboratory procedures | |
| | | | Develop uniform assessment tool and common care platform | |
| | | | Pool non-Medicaid state dollars into pilot IDSs or community health improvement models | |
| | | | Change Health Facilities and Services Review Board to incorporate community-based and ambulatory services into their standards | |

(continued)

Appendix Table 12A-1. Models and strategies proposed in Illinois Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|--|---|-----------------------|---|--|
| Workforce development New health care worker roles: Develop CHWs, a new health care labor category; community paramedics; peer mental health counselors; others Expand the role of home care aides, especially those who care for people with specific needs | CHW training program at Governors State University College of Direct Support programs Enhanced training for home care aides developed by the Service Employees International Union, Chicago Federation of Labor, and 5 home care agencies | N/A | <p>Proposed executive branch actions</p> <ul style="list-style-type: none"> *Combine current Medicaid section 1915(c) waivers through Community First Choice or a section 1115 waiver (in process) *Create access to the IL HIE for community-based organizations and social service providers outside the traditional health care system File state plan amendment to establish health homes Engage state and county employees' health benefits administrators Pursue approval to use federal matching dollars in Medicaid for services like housing <p>Proposed federal action</p> <ul style="list-style-type: none"> Change federal law to ease the sharing of substance abuse treatment information | Universities, hospitals, state agencies including Medicaid |
| | | | <p>Existing</p> <ul style="list-style-type: none"> Illinois Department of Financial and Professional Regulation agreed to credit military training towards the education requirements of Illinois-approved licensed practical nurse education programs <p>Proposed state legislative action</p> <ul style="list-style-type: none"> *Develop and enact legislation for CHW training and certification <p>Proposed state regulatory action</p> <ul style="list-style-type: none"> *Revise scope of practice regulations | |

(continued)

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Appendix Table 12A-1. Models and strategies proposed in Illinois Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|---|---|--|---|--|
| Enhance the scope of practice to allow all professionals to work at the top of training/ education Expand primary care capacity serving vulnerable populations Train future providers in working within a patient-centered medical home and IDS | | | <p>Proposed executive branch actions</p> <ul style="list-style-type: none"> *Medicaid section 1115 waiver to fund GME pilot program, loan repayment, and training *Develop payment models that support the use of CHWs *Change Rule 132 that authorizes which mental health providers can bill Medicaid, and defines the structure, definition, and financing of services provided by community mental health centers, to increase access to community-based behavioral health care services <p>Resources requested in Governor’s proposed fiscal year 2015 budget</p> <p>Proposed state facilitated system change</p> <p>Through a new advisory board, standardize and coordinate scope of practice acts that would be considered by the Illinois legislature</p> <p>Invest in training for home care aides</p> | |
| <p>Public health strategies</p> Pilot an ABCD model to address the social determinants of health for the newly Medicaid-eligible population (e.g., housing, employment, social supports) and integrate with Medicaid delivery systems | New Communities: private foundation–funded ABCD program | Low-income population and general population | <p>Potential state regulatory action</p> <p>Reevaluate state laws and regulations that limit the public’s access to public health data</p> <p>Proposed executive branch actions</p> <ul style="list-style-type: none"> *Promote the transparency of both hospital-created CHNAs and the IDPH–produced Illinois Project for Local Assessment of Needs *Synchronize needs assessment and planning timeframes for LHDs and hospitals (CHNAs) | IDPH, local health departments, non-profit hospitals |

(continued)

Appendix Table 12A-1. Models and strategies proposed in Illinois Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|---|---|-----------------------|---|--|
| Develop a regional public health structure (Regional Hub) to connect the IDPH, LHDs, communities, and the Alliance efforts to support population health improvement; calculate return on investment | | | Potential executive branch actions Consider development of wellness trusts and social impact bonds Explore pooled funding for community-based social services | |
| Align existing health planning efforts | | | | |
| Enhanced data analysis | Current Alliance infrastructure | N/A | Proposed state legislative action *Seek enabling legislation for the APCD Potential state regulatory action *Develop a plan to require all Medicaid providers to share patient encounter data with health plans or the state through their regional HIEs or the IL HIE Proposed executive branch actions *Establish the Office of Health System Transformation within the Governor’s Office through executive order Seek federal flexibility on “Qualified Entity” status to allow the state better access to Medicare data Proposed federal action Explore the potential for Medicare to require that providers participate in HIE | State agencies, health plans, Medicare |
| Establish an Innovation Transformation Resource Center | | | | |
| Develop an APCD | | | | |
| Establish the Governor’s Office of Health System Transformation | | | | |

¹Policy levers include Medicaid waivers; federal grants (including Round 2 SIM award); state laws; state regulations; state investments (e.g., in public health programming); foundation grants; employer-led coalitions to drive change among providers, purchasers, or plans; state government-led coalitions, task forces, or commissions to drive voluntary change among providers, purchasers, or plans; state purchasing contracts; and state-level (Governor-initiated) executive policy directives.

Appendix Table 12A-1. Models and strategies proposed in Illinois Health Care Innovation Plan (continued)

Abbreviations: ABCD = asset-based community development, ACE = accountable care entity, ACO = accountable care organization, APCD = all-payer claims database, CCE = care coordination entity, CHNA = community health needs assessment, CHW = community health worker, GME = graduate medical education, IDPH = Illinois Department of Public Health, IDS = integrated delivery system, IL HIE = Illinois Health Information Exchange, LHD = local health department, MCO = managed care organization, N/A = not applicable.

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13. Iowa

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Iowa's State Innovation Model (SIM) Initiative was part of a larger state effort to move Iowa's health care system toward value-based purchasing using a multi-payer accountable care organization (ACO) model. As Iowa developed its Health Care Innovation Plan (the Plan), a number of ACO-like initiatives already existed in the state. From the beginning, the state intended to use the Initiative to expand the ACO model, to help control rising health care costs. The planning process was joint between the Governor's Office and the state Department of Human Services, which chose specific stakeholders to participate in a number of work groups. Three public "learning sessions" were held to obtain wider stakeholder input.

The Plan builds on existing initiatives in both the public and private sectors to implement a multi-payer ACO by stages, with the goal of full ACO capitation by 2020. The first stage has already been established, a Health and Wellness Plan for people below the federal poverty line who are ineligible for Medicaid. The second stage would expand the ACO model to the whole state Medicaid population. In the third stage, Medicaid ACOs would be held accountable for total care costs, including behavioral health services and long-term care services. The eventual Plan target is to reach 80 percent of Iowans by persuading Medicare ACOs to adopt the same performance measures as used by the state. The state plans to use state legislative and regulatory action, as well as voluntary payer cooperation, and is considering submitting a Medicaid section 1115 waiver application or a state plan amendment to enable the statewide Medicaid ACO expansion.

13.1 Context for Health Care Innovation

Several contextual factors were particularly relevant to shaping Iowa's Health Care Innovation Plan (the Plan). These factors include a concentrated health care market, growing health care costs, and growing momentum around the ACO model.

Health care market and system. In Iowa, a few large entities dominate the health care market, with a history of collaboration. Wellmark Blue Cross Blue Shield (Wellmark) is the dominant insurer across the small group, large group, and individual markets (Iowa Department of Human Services, 2013a), and its ACO models currently serve 64 percent of counties in the state. Likewise, a few large integrated health systems (e.g., Iowa Health System, Mercy Medical Center, and Genesis Health System) deliver a majority of acute health care and employ more than half of the primary care physicians in the state. This concentrated, collaborative environment has created an opportunity for systemwide change.

Growing health care costs. On most measures of per capita spending, Iowa does not substantially differ from national averages (SHADAC, 2012), and the state's health care system is relatively cost-effective and high quality compared to other states (consistently ranking among the top five). However, both commercial insurance premiums and state Medicaid costs continue to rise at rates the state considers unsustainable (Iowa Department of Human Services, 2013a). Major contributors to these rising costs are the high rate of mental illness and substance abuse disorders among Medicaid enrollees, and growing costs required for long-term services and supports (LTSS). In response, Governor Terry Branstad convened a work group in 2011 to develop recommendations for addressing the rising cost of health care. The work group included a variety of public and private stakeholders, including the state's largest private health care systems, Iowa Medicaid Enterprise (IME), Wellmark, and both of the state's medical schools, among others. Containing health care costs has remained on both the Governor's and the state legislature's agenda (Iowa Department of Human Services, 2013c).

Growing support for the ACO model. One recommendation that came out of the Governor's work group on health care costs was to implement a multi-payer ACO methodology. Since then, a number of initiatives in Iowa have been developed that use the ACO model. In 2011, Wellmark worked closely with key integrated health care systems to develop an ACO model, which was implemented in several regions across the state in 2012. In addition, several organizations in Iowa are participating in the Centers for Medicare and Medicaid Services' (CMS's) Pioneer ACO and Shared Savings ACO programs for Medicare beneficiaries.

State legislation in 2013 created Iowa's Health and Wellness Plan, which provides coverage for low-income adults (under 133 percent of the federal poverty level [FPL]) who are not eligible for Medicaid. This legislation represented a significant compromise between the Governor and Iowa's senate. As part of the compromise, eligible participants will pay a small monthly premium to participate in eligible plans. This alternative to Medicaid expansion was approved by CMS in December 2013 under a section 1115 demonstration waiver (Iowa Medicaid Enterprise Website, 2014). Adults from 100 to 133 percent FPL will receive premium assistance to select a commercial health plan through the federally managed health insurance marketplace or through an employer-sponsored program. Individuals with incomes below 100 percent FPL will be covered through the state-run Wellness Plan, using a managed care approach and ACO enrollment where available. Individuals from 0 to 133 percent FPL who are identified as medically frail will have an option to be covered through the Medicaid State Plan.

Other relevant initiatives. A number of other state-driven health initiatives occurring at the time of the SIM Initiative are relevant to the Plan's development process. One example is the Governor's Healthiest State Initiative, which aims to make Iowa the healthiest state in the nation in the next 5 years. This initiative includes a number of programs that encourage Iowans to make lifestyle changes that will improve their physical and mental health. It also includes a

collaboration with Wellmark to build community environments that support healthy lifestyles (such as through the availability of fresh produce, bike lanes, and playgrounds). The state was also in the midst of a major Mental Health and Disability Services redesign, which involved input from relevant stakeholders through a number of work groups. In addition, Iowa has implemented the Health Home initiative, targeted at Medicaid beneficiaries with chronic conditions, and an Integrated Health Home initiative for Medicaid beneficiaries with behavioral health conditions.

13.2 Planning Infrastructure and Process

Stakeholders indicated that the state Department of Human Services (DHS) and the Governor's Office worked closely to manage the Model Design process. Many stakeholders felt that the state had already committed to an ACO model as the main component of the Plan and was looking for stakeholder approval and refinements of that model. Stakeholder engagement in the Plan development process occurred primarily through four work groups that devised and submitted recommendations to a Steering Committee. These work groups comprised mostly stakeholders from the Des Moines area, because the groups met in person in that city and no compensation was offered. However, some members were from outside Des Moines and meetings were attended by non-members from all parts of the state. The state engaged consumers and stakeholders outside the Des Moines area through listening sessions held throughout the state.

Governance and management. The Model Design process was a joint effort between the Governor's Office and DHS. Stakeholders recognized the state Medicaid Director as the primary leader of the process. The DHS Director and the Medicaid director met weekly with the Governor's Health Policy Advisor and the Iowa Insurance Commissioner to provide updates on the process (Iowa Department of Human Services, 2013b). The Governor's Health Policy Advisor chaired the Steering Committee, and one stakeholder indicated the Governor was "very involved." Leadership from DHS, the Insurance Department, and the Department of Public Health also participated in the Steering Committee (Iowa Department of Human Services, 2013a). Additionally, after the work groups had concluded their meetings, IME staff and the SIM Initiative work group chairs presented the Plan to the legislative study committee on Integrated Health Care Models and Multi-payer Delivery Systems.

Stakeholder engagement. The Governor's Office and DHS together selected stakeholders to engage in the work groups and the Steering Committee, with the Governor's Office extending invitations directly. According to the Plan, "many of the Steering Committee members were part of the work group of health care leaders that [the] Governor ... had convened in 2011" (Iowa Department of Human Services, 2013a). The state also held three public "learning sessions" at which it invited individuals who wanted to be involved in the Plan

development process to contact officials. One stakeholder indicated that the state was welcoming when the organization initiated its own involvement in the work groups. Stakeholders agreed that the state was inclusive. No one identified any stakeholder groups as missing from the process.

Work groups. Each of the work groups addressed one of four aspects of the state's vision of health care transformation: metrics and contracting, member engagement, behavioral health integration, and LTSS integration. The types of stakeholders represented varied across the work groups, although providers were heavily represented on all groups and on the Steering Committee. Consumers and their advocates were not well represented in the work groups, however, comprising less than 8 percent of the 69 individuals engaged in the work groups and the Steering Committee (Iowa Department of Human Services, 2013a). Each work group met four times before submitting recommendations to the Steering Committee, which met once. The state contracted with Health Management Associates to facilitate and document the work group process. Stakeholders generally felt the contractor did a good job of facilitating the meetings, preparing participants for discussion, communicating with participants and sharing documents, and keeping the conversations across work groups in alignment.

Stakeholders agreed that the state had already determined an ACO model would be the foundation of the Plan, before convening the work groups. Although some felt the state was not transparent regarding the decisions it had already made, or that stakeholder engagement was only a formality, the centrality of the multi-payer ACO model was explicit in the SIM application. Still, multiple stakeholders praised the collaborative nature of work group discussions and believed the state considered their input in developing the Plan. Notably, the state engaged a group of pediatric care advocates in separate meetings in response to the volume of their input. One provider we spoke with indicated the state revised its initial regional mapping scheme based on stakeholder input. At least one stakeholder from an infrastructure organization felt that ACOs wielded more influence in the process than they should have, given how recently they have been implemented in Iowa.

The facilitators gave work group members the opportunity to prioritize the suggestions that came out of their work groups, and several common themes surfaced in each group. However, some work groups reached consensus and others did not; no voting or formal consensus process was used (Iowa Department of Human Services, 2013a). One provider felt that, in some cases, a work group recommendation made to the Steering Committee reflected only the opinion of one person in the group. The Steering Committee engaged in a discussion of the work group recommendations on what the Plan should ultimately include, but did not use any formal voting process (Iowa Department of Human Services, 2013a). The Governor's Health Policy Advisor and the Medicaid Director led the Steering Committee discussion, and were said to be likely influential in both the committee's final decisions around the content of the Plan and

the translation of those decisions into the final Plan document, which was written after the Steering Committee meeting.

Consumer and public engagement. Iowa engaged the public on multiple fronts—connecting with stakeholders not represented in the work groups through six “listening sessions,” in which state officials discussed both the SIM Initiative and the Iowa Health and Wellness Plan. Sessions were held across the state and hosted by Area Agencies on Aging. In addition to these listening sessions, the formal work group meetings were open to the public and included a dedicated period for public comment. Finally, before the work group recommendations were shared with the Steering Committee, consumer advocates were invited to attend either of two consumer-focused public meetings at which IME presented the recommendations. Throughout the process, work group materials, agendas, and minutes were publicly available on the IME Web site. Regarding the state’s engagement of the public, one stakeholder said, “I would say this was probably government working with its constituency in some of the best ways I’ve seen in a long time.” Stakeholders were also satisfied with the engagement of individuals from multiple parts of the state.

State and SIM resources. DHS contracted a Telligen employee to serve as project manager for the SIM Model Design process. In addition to Health Management Associates, the state contracted with Treo Solutions to support development of the Plan and contracted with Milliman to provide actuarial support (Iowa Department of Human Services, 2013b). The state indicated that it could have benefited from having more staff, but also noted that the short duration of the award made it difficult to hire additional individuals through state hiring authorities. The time the work group members dedicated to the Model Design process, including that of state officials participating as stakeholders, was uncompensated. One stakeholder from an organization in Iowa’s health care infrastructure suggested that the process would have been better if the Model Design award had been used to bring particular stakeholders to the table or to support additional meetings.

Additional planning efforts. With SIM award funds, the state compiled a set of analytic and explanatory materials, which it made publicly available on the state’s SIM Web site, to inform stakeholders throughout the planning process, and to support the needs of the work groups. Key documents supporting the state’s approach included a Center for Health Care Strategies brief describing the Medicaid ACO approach (Mahadevan, 2013), a case study of Wellmark’s 2012 implementation of its ACOs in Iowa (Treo, 2013a), and an analysis of existing geographic networks of the Medicaid program (Treo, 2013b). The geographic analysis, in particular, helped the state form the initial proposal for regional ACO boundaries.

13.3 The Iowa Plan

Iowa has been strategic about planning to move its health care delivery system from a fee-for-service system to a system that is “value-based, accountable, [and] integrated” (Iowa Department of Human Services, 2013a). The primary vehicle for this effort is implementation of a multi-payer ACO. The multi-payer component would occur through creation of a Medicaid ACO, which would build on the Iowa Health and Wellness Plan and align with Wellmark’s ACO performance measurement and payment methodology. Together, Wellmark and the state cover 70 percent of Iowans. Therefore, aligning Medicaid and Wellmark would provide a critical mass of ACO-covered patients and move providers toward population-based care. The state also plans to seek participation by the Medicare ACOs, which would bring the total lives covered to 86 percent of Iowans.

13.3.1 Models and Strategies

The Plan describes three major strategies to achieve its “to be” state: (1) implement a multi-payer ACO methodology across Iowa’s primary health care payers; (2) expand the multi-payer ACO methodology to address integration of LTSS and behavioral health services; and (3) incorporate population health, health promotion, and member incentives to reward healthy behaviors. The Plan uses an ACO model of payment and delivery reform and incentives for consumers through insurance benefit design, as described below. *Appendix Table 13A-1* provides a summary description of the innovations proposed, initiatives on which they are built, populations they address, proposed policy levers, and supporting implementation entities.

ACO model. The state’s primary goal, encompassing all three strategies, is to implement an ACO aligned with the performance measurement methodology used by Wellmark’s existing ACOs in the state, thus creating what it calls a multi-payer ACO. The Plan describes implementation of the ACO model in three phases. Phase 1 was implementation of the Health and Wellness Plan in January 2014, which includes an ACO option for individuals not eligible for Medicaid whose income is below 100 percent FPL. Phase 2 would expand the ACO model to the entire Medicaid population in 2016, using six regional Medicaid-contracted ACOs. During Phase 2, ACOs would be accountable for the total cost of care and quality measures for physical health only. Although not yet completely defined, the state’s Plan states that an adaptation of the Treo Value Index Score (VIS) currently used to measure the performance and determine payment for Wellmark’s ACOs would be used for Medicaid-contracted ACOs. However, modifications to the VIS are expected. For example, in response to work group feedback, the state promises to incorporate better measures of performance in pediatric settings.

The state’s second major strategy is scheduled for implemented during Phase 3, when Medicaid-contracted ACOs would be accountable for the total cost of behavioral health services (starting 2017) and LTSS (starting 2018). This represents an expansion of the ACO model

beyond what exists in the commercial market. The phased integration of these services is seen as necessary, since even more extensive modification of the VIS performance and payment system would need to be developed for these services.

In general, the Plan seeks to provide flexibility for ACOs to develop their own approaches. This includes not only details of how care teams are organized, but also how workforce development takes place to ensure an adequate supply of appropriate care givers. IME realizes the importance of supporting ACOs as they develop and implement their own strategies, and has reflected this in the Plan.

Consumer engagement. The state plans to leverage its role as a major health care purchaser to promote expanded use of preventive care, adoption of healthy behaviors, and improved member engagement. A feature of the state's newly approved section 1115 waiver is the opportunity for members to avoid premiums (persons with incomes above 50 percent FPL currently pay premiums) if they complete wellness activities. As part of the Plan, organizations seeking to become ACOs in the Iowa Health and Wellness Plan will be required to develop strategies to encourage member engagement in these activities. Consistent with the recommendations of the metrics and contracting work group, the Plan does not have specific requirements for what those strategies should include.

Health information technology (health IT). To support development of a multi-payer ACO model, the state plans to make improvements in its existing e-Health foundation. This includes both accelerating efforts already under way, as outlined in the Strategic Operations Plan developed under its cooperative agreement with the Office of the National Coordinator for Health IT, and new efforts specifically aimed at supporting accountable care. Ongoing efforts aim to increase provider adoption of electronic health records and development of a hybrid federated health information exchange (HIE) infrastructure. New efforts would enhance the HIE to support communication across regional ACOs, expand data analytic capacity developed for Medicaid health homes to ACOs, build capacity for real-time notifications of health care events to ACOs, and build shared systems to give health IT access to smaller providers.

Other models and strategies considered for the Plan but rejected. The three strategies in the Plan are the same three originally included in the state's SIM Model Design application. Although some features of these strategies may have been refined during the planning process, such as the precise boundaries recommended for ACO regions, no other strategies were considered.

13.3.2 Policy Levers

Aligning its Plan with an existing state program (the Health and Wellness Plan) would enable the state to leverage a number of existing policies, particularly state legislative action

passed related to that program. The state also plans to leverage state regulatory, executive branch, voluntary, and federal government action to implement the Plan. Existing and proposed policy levers for Plan implementation are listed in [Appendix Table 13A-1](#).

State legislative action. The Plan builds, most importantly, on the Health and Wellness Program for low-income adults not eligible for Medicaid, which was passed by the state legislature in May 2013. This legislation authorizes use of payment models that include, but are not limited to, risk sharing between the state and participating ACOs, and bonus payments for improved quality. The legislation also develops a mechanism for providers to be reimbursed for providing care coordination services. These components of the legislation set the foundation for the statewide ACO model for Medicaid beneficiaries in the Plan. Also important in this connection is the e-Health initiative approved by the legislature in 2008.

State regulatory action. The state is monitoring whether any regulatory changes are required for the Iowa Health and Wellness Plan, and will use the lessons learned to plan for any future rules needed for the Medicaid ACO to be successfully implemented.

State executive branch action. In December, Iowa received approval from CMS on the section 1115 waiver for its Wellness Plan (Iowa Medicaid Enterprise Website, 2014). The state plans to assess whether it is necessary to submit a section 1115 waiver application or a state plan amendment to implement the statewide Medicaid ACO. In addition to the ACO, the Plan includes elements to support the Governor’s Healthiest State Initiative. The incentives for consumers to promote preventive care and healthy behaviors align with this initiative.

Voluntary action. The multi-payer model in the Plan relies on collaboration across payers. Although the state has some control over Medicaid health plans, it must rely on voluntary collaboration from Wellmark to share its ACO methodology, so the state can align with it. In addition, the state is hoping the Medicare ACOs will voluntarily adopt the same performance measures for the Plan in order to affect at least 80 percent of Iowans. The third major strategy described in the Plan—increasing individuals’ engagement in their health—is also supported by the voluntary Blue Zone project, which encourages participating communities to provide citizens easy opportunities to make healthy choices, including physical activity.

Federal action. The state will apply for a Round 2 Model Test award to support implementation of its Plan.

13.3.3 Intended Impact of the Plan

A major goal of the Plan is to include enough of Iowa’s population in a multi-payer ACO model to move the health delivery system toward population-based care. By doing so, the state hopes to achieve reduced costs, improved health, and improved patient experience of care. Specifically, the Plan expands the ACO model to Medicaid populations in all regions of the state

through six regional ACOs. These regions were identified by Treo Solutions through analysis of Medicaid practice and referral patterns as part of the SIM Initiative, and modified based on feedback from providers on work groups. The Plan also addresses particularly high-cost populations, such as people with mental illness and the aging or disabled population, by eventually holding ACOs accountable for the cost of behavioral health services and LTSS. By aligning the performance measurement and payment methodology used by the state, Wellmark, and Medicare ACOs, as noted, the Plan is intended to reach at least 80 percent of the state’s population.

13.3.4 Proposed Next Steps

Implementation of the Plan would be led by the IME within DHS. The Plan lays out a number of concrete next steps as shown in *Table 13-1*.

Table 13-1. Next steps for Health Care Innovation Plan implementation in Iowa

| Timeframe | Action |
|------------------------|--|
| Winter 2014 | Iowa Health and Wellness Plan Implementation and Round 2 Model Test award proposal |
| Spring/Summer 2014 | State to issue request for information for prospective ACOs |
| Fall 2014/Winter 2015 | State to issue RFP for prospective ACOs |
| Winter/Spring 2015 | State to select regional ACOs |
| January 2016 | ACOs to be implemented; during first year, ACOs to be held accountable for quality measures and total cost of care for physical health services only |
| January 2017 | ACOs to be held accountable for total cost of care (including behavioral health and long-term services and supports) |
| State Fiscal Year 2020 | ACOs to be fully capitated |

13.4 Discussion

The Plan was shaped by state context and commitment to a coordinated vision for state health reform. Iowa has the conditions under which state-driven, widespread reform may be feasible, according to stakeholders, because nearly 70 percent of the population is already covered by the state and one dominant carrier, and a few highly integrated health systems dominate the market in much of the state. Stakeholders had some concerns over heavy reliance on one relatively new model to reform the system. But overall, they were pleased with the state’s effort to include broad representation in the Plan development process and felt it was an opportunity for a variety of stakeholders to come together that would not have otherwise occurred. However, stakeholders recognized that they were likely only able to influence the Plan on the margins. Many felt the decision to use the ACO model for state health reform was already

made by state leadership. Questions were also raised as to whether this model would best address the needs of all populations, and whether it would ultimately be sustainable.

13.4.1 Critical Factors Shaping the Plan

The most important factor shaping the Plan, according to stakeholders, was likely the state's existing interest in developing a regional ACO model for its Medicaid population that would align with existing ACO infrastructure. Stakeholders also described the large, if indirect, influence of Wellmark, the state's largest private payer, and three large health systems engaged in ACO arrangements already present in most of the state. However, stakeholders indicated that Wellmark did not appear to have much direct influence in the work groups. They indicated that IME sought Wellmark's support in developing a multi-payer ACO model years before the SIM Model Design process began, and that Wellmark had the opportunity to review the state's application for the Model Design award (although mostly to verify the accuracy of the Plan's references to Wellmark). One stakeholder also said the state had already made the decision to use Wellmark's VIS as quality measures for the state ACOs. However, multiple stakeholders from provider, consumer, and payer groups noted the assertive participation of pediatric care advocates in the work group deliberations, and their influence in the state's consideration of augmenting the VIS with other measures to reflect care quality for pediatric populations.

13.4.2 Lessons Learned

A number of lessons emerged around the use of a work group structure to facilitate stakeholder engagement. Overall, stakeholders felt the work groups were a valuable vehicle for stakeholders, even within the same area of health care, to come together for discussion where previously no history of collaboration existed. The opportunity to bring together different components of what stakeholders described as a fragmented health care system was a positive outcome resulting from the Model Design process that would not have happened otherwise.

- **Aggressive timelines put constraints on the process that can be used for Plan development.** Stakeholders agreed that the aggressive timeline of the Plan development process created significant drawbacks. First was lack of time to develop a common understanding around the charge of the work groups. Some work group participants initially approached the process ready to argue for their vested interests in the current system; the process was significantly under way before they oriented themselves to thinking more broadly about system transformation. Some stakeholders noted that the inexperience of commercial payers and health systems in incorporating public input into decisions introduced tension to the discussion—and that additional time might have facilitated better collaboration between large health systems and payers and community-based providers more accustomed to working with IME and its beneficiaries. Additionally, stakeholders believed that more time would have allowed them to create a more substantive Plan. Some also felt they did not have enough time to properly review their work group's recommendations before they

were synthesized for the Steering Committee to review, or to properly present the diversity of perspectives represented and the output of their deliberations. Additional time might also have helped build trust among stakeholders who felt the state was not wholly interested in their input—as was the concern among some community-based behavioral health providers.

- **Facilitators of the process have significant impact on the quality of the discussion and on Plan content.** Stakeholder perspectives also indicate that the information facilitators selected to present to stakeholders in the work groups may have affected the quality of the discussion and the content of the Plan. Many stakeholders noted that the facilitators did a good job of gathering and presenting informative materials to prepare stakeholders for work group discussion. However, one stakeholder felt that lack of material on alternative payment and delivery models relative to the amount of material presented on ACO models would have made it difficult for stakeholders to make a case for a different model. Stakeholders also noted that lack of technical knowledge among many stakeholders regarding payment and delivery models was a barrier to work group productivity.

13.4.3 Potential for Implementation

Given the strong support in state government for expanding the ACO model, it is considered likely that at least some elements of the Plan will move forward with or without a future Round 2 Model Test award. Part of the Plan's strength is its full integration into existing Iowa initiatives and its development as part of a larger vision for state health reform. Therefore, much of the infrastructure needed to expand the ACO model to Iowa's Medicaid population already exists. Some stakeholders interviewed before CMS approved Iowa's Health and Wellness Plan alternative to Medicaid expansion were concerned about what lack of approval would mean for the Plan; but these concerns may no longer be relevant given that the waiver has been approved.

The goal of aligning Medicaid, Medicare, and private payers in a consistent ACO framework would require several steps. The state can mandate use of a payment methodology based on the VIS that is consistent with Wellmark's existing ACOs. Implementation, however, would require building out the state's HIE system to support performance-based payments in the Health and Wellness Plan. The state then plans to build on that method to include performance metrics appropriate for behavioral health services and LTSS. This would require additional analytic work and negotiation with those service providers. The state believes that alignment with Medicare ACOs would be facilitated by the high degree of provider overlap across Medicare, Medicaid, and private payers. And it predicts efficiencies for providers, who would have consistent incentives in treating patients regardless of the source of payment. This reduced administrative burden could be a selling point if modification to an existing ACO payment model is necessary to achieve alignment.

However, the state's strong, singular focus on the ACO model also has some drawbacks. For one, the Plan depends on the voluntary cooperation of Medicare ACOs to adopt the multi-payer methodology the state proposes, without which the Plan would not reach 80 percent of Iowa's population. Whether these ACOs would align with the state's vision is unclear. The concerns of pediatric providers about the appropriateness of existing ACO value measures for the pediatric population suggests even greater barriers in establishing a common set of metrics that also include the elderly and disabled populations served by Medicare ACOs. In addition, some stakeholders expressed uncertainty around such heavy reliance on ACO models, given that the models are relatively new. One stakeholder observed that no one has actually seen an ACO yet, saying, "Everybody's preparing to do it, but nobody's actually doing it. It would be nice to see what it looks like. So it's positive that you can be part of that design, but frightening because you don't know exactly what it's going to be like."

Stakeholders in the metrics and contracting work group also expressed concern about the sustainability of the ACO model, particularly in a state that already has relatively high quality of care, low reimbursement rates, and little excess supply of hospitals or specialists in rural areas. If one of the requirements of a sustainable ACO model is to generate new savings each year, it may quickly become difficult to do so. Some stakeholders also felt the ACO model may not be the best fit for every population, saying, for example, that ACOs may work better in metropolitan areas where a sufficient volume of patients is available to achieve greater efficiencies. This was a particular concern among rural hospitals, which are already pretty lean. One stakeholder questioned the need for an ACO in small communities, saying, "In a small community, everybody knows everybody and we already have relationships. We've already achieved a lot of the goals that an ACO sets out to do." Stakeholders also worried that ACOs may not be the best fit for specific subpopulations, who may get lost when the focus is on overall costs. For example, some pediatricians raised the concern that ACOs draw a health system's focus toward high-cost populations such as the chronically ill or the elderly, and away from traditionally lower-cost populations, such as children. In addition, some community-based and nontraditional providers were unclear how they would fit into an ACO model, which would likely shift patients toward using larger health care systems. And some providers were concerned about whether they would qualify to participate and receive payments within an ACO model.

Multiple stakeholders were concerned that the substantial work the state has been doing to redesign Mental Health and Disability Services (which are currently managed through a behavioral health carve-out in Medicaid) was not incorporated into the Plan. While the Plan describes the ACO model as being aligned with the redesign, some were disappointed that, after the effort and progress made in the delivery of these services, behavioral health is to be ultimately incorporated into the ACO model, and felt that the state was essentially ignoring all the work already done. One stakeholder worried the delay in integrating behavioral health into the ACO model indicates that the state is not serious about truly treating the whole person. From

a political standpoint, interviewees told us that the senator who initiated the mental health redesign is running for Governor against the incumbent (also the longest serving Governor in the country), signaling to these observers that this senator has a lot at stake in the redesign—and that politics may ultimately affect whether behavioral health is incorporated into the ACOs.

13.4.4 Applicability to Other States

Because the Plan was largely driven by Iowa’s state context, it may have limited applicability in other states according to interviewees. In particular, Iowa has strong support for the ACO model from the highest levels of state leadership, and a history of collaboration among the few large entities that dominate the health care system. The Plan’s multi-payer ACO model leverages the considerable amount of ACO infrastructure already in place in the state. Furthermore, the state’s success in aligning its model with commercial payers may have been largely facilitated by the dominance of a single payer in the commercial coverage market, and a few large, integrated health care systems.

13.4.5 Limitations of This Evaluation

These findings represent the views of a sample of stakeholders who were interviewed about the process. In general, the views of those heavily involved in the process may be overrepresented. In addition, the views of some stakeholder groups are reported here based on secondhand information, or on how interviewees summarized different perspectives among other stakeholders. With the exception of one person, none of the stakeholders with whom we spoke had the opportunity to review the Plan before our conversation. Thus, the stakeholder comments reported here may not accurately reflect opinions of the final Plan. Neither did the stakeholders we interviewed include any consumers or members of the public engaged through the consumer work groups or the listening sessions convened by the state—limiting this study’s ability to evaluate the success of those methods of engagement or their influence on the Plan.

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Appendix Table 13A-1. Models and strategies proposed in Iowa Health Care Innovation Plan

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|--|--|---|--|--|
| Accountable care organization Regional Medicaid-contracted ACOs | Health and Wellness Plan Wellmark ACOs Medicare Pioneer and Shared Savings ACOs | Adult and child Medicaid and CHIP beneficiaries Later phases will address populations that are mentally ill or elderly | Existing *Iowa Health and Wellness Plan (passed by Iowa Legislature, May 2013) *Section 1115 waiver for Iowa Health and Wellness Plan (approved December 2013 by CMS) Proposed state regulatory actions To be determined Potential executive branch action Additional section 1115 waiver or SPA for implementing statewide Medicaid ACO Proposed federal actions Round 2 Model Test award Proposed state facilitation of system change *Sharing of ACO methodology for quality measures by Wellmark ACOs Adoption of same performance measures by Medicare ACOs | Iowa Department of Human Services through IME |
| Consumer engagement Incentives to consumers and providers to promote preventive care and adoption of healthy behaviors | Health and Wellness Program incentives for consumers and providers Governor’s Healthiest State Initiative | Health and Wellness Plan-covered individuals | Existing *Iowa Health and Wellness Plan (passed by Iowa Legislature, May 2013) *Section 1115 waiver for Iowa Health and Wellness Plan (approved December 2013 by CMS) Proposed state regulatory actions To be determined Proposed executive branch actions Alignment of consumer incentives within ACO model with Governor’s Healthiest State Initiative | Iowa Department of Human Services through IME |

(continued)

Appendix Table 13A-1. Models and strategies proposed in Iowa Health Care Innovation Plan

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|--|---|-----------------------|--|---|
| Health information technology Expanding and Enhancing the Capacity of Iowa's Health Care Information Systems to Support Accountable Care | Hybrid federated HIE E-health stakeholder engagement plan | N/A | Existing *Iowa E-health initiative (passed by legislature in 2008) *Strategic Operations Plan (developed in 2010 with ONC) *EHR incentive program (begun in 2011) *Iowa Health Information Network (passed by legislature in 2012) Proposed state regulatory actions To be determined Proposed executive branch actions Increase Medicaid provider adoption of EHRs (in process) Support connectivity of public health care and surveillance systems to HIE (in process) Expand web portal to members of care team for Medicaid enrollees | Iowa Department of Human Services (specifically, IME) |

¹Policy levers include Medicaid waivers; federal grants (including Round 2 SIM award); state laws; state regulations; state investments (e.g., in public health programming); foundation grants; employer-led coalitions to drive change among providers, purchasers, or plans; state government-led coalitions, task forces, or commissions to drive voluntary change among providers, purchasers, or plans; state purchasing contracts; and state-level (Governor-initiated) executive policy directives.

Abbreviations: ACO = accountable care organization, CHIP = Children's Health Insurance Program, CMS = Centers for Medicare & Medicaid Services, EHR = electronic health record, HIE = health information exchange, IME = Iowa Medicaid Enterprise, N/A = not applicable, ONC = Office of the National Coordinator for Health IT, SIM = State Innovations Model, SPA = (Medicaid) state plan amendment.

14. Maryland

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Maryland’s experience with new delivery and payment models and statewide approaches, combined with robust data resources and a political leadership supportive of health care reform, created the backdrop for its State Innovation Model (SIM) Model Design process. To present its concept for a community-integrated medical home (CIMH) with a “practice side” and a “community side,” the state held a series of public stakeholder meetings to attract the participation of a wide range of individuals and groups. The meetings were chaired by the Deputy Secretary for Public Health Services and facilitated by Health Quality Partners (HQP), a nonprofit health care quality research and development organization.

On the practice side, the Health Care Innovation Plan (the Plan) proposes to increase provider participation in patient-centered medical home (PCMH) models. On the community side, the state will establish community health hubs (CHHs) to provide community interventions to individuals based on geographic areas of health disparities or disproportionate use of health care services.

The Plan establishes a new public utility to provide governance of the CIMH. Medicare is envisioned as joining existing multipayer PCMH efforts on the “practice side”. On the community side, Medicare fee-for-service (FFS) beneficiaries will be the initial target population, with voluntary participation of commercial, public, and self-funded health plans, based on demonstration of value. State legislation establishing the CIMH program is the main policy lever for Plan implementation. The state anticipates that recent changes to the all-payer Medicare waiver will encourage broad voluntary support for the community side of the CIMH model. The state aims to have to have 80 percent of Marylanders receiving care within a CIMH by the end of 4 years. The CHH reach is projected to be much smaller, though accounting for the majority of the estimated net savings through reductions in avoidable health care use among high risk populations.

14.1 Context for Health Care Innovation

Several contextual factors are relevant to the process Maryland used and the CIMH model proposed. These include experience with single- and multi-payer PCMH models; an existing statewide infrastructure for local health improvement; statewide, all-payer hospital rate setting; robust data resources; a sufficient physician workforce; and political leadership supportive of health care reform.

PCMH experience. Experience with PCMH models influenced selection of this model as the basis for the “practice” side of the CIMH. CareFirst BlueCross BlueShield is the dominant carrier and has operated a single-payer PCMH program in the state since 2010. Cigna has operated a single-payer PCMH program in Maryland since February 2013. The six major commercial payers and six of the seven Medicaid managed care organizations participate in the multi-payer state PCMH program, led by the Maryland Health Care Commission (MHCC). The state legislation authorizing the program was enacted in 2010 and sunsets at the end of 2015. Nearly 1.3 million of 5.6 million state residents and 2,800 of 4,500 primary care physicians and nurse practitioners are currently covered by a PCMH model. At the start of the planning process, Maryland had 10 accountable care organizations, many of which include practices in PCMH programs (DHMH SIM Stakeholder Meeting Slides, 2013; MHCC, 2013; DHMH Draft Plan, 2013).

Existing population health framework. Maryland established a framework called the State Health Improvement Process (SHIP) in 2011 to facilitate shared accountability between health care settings and the community (DHMH SHIP, 2013). This framework aims to catalyze local action and integrate the efforts of hospitals, health care providers, community groups, the public health sector, and the health insurance marketplace. Under the framework, DHMH established 18 public/private local health improvement coalitions (LHICs). LHICs receive funding from the state and hospitals, and are also supported through grants from the Centers for Disease Control and Prevention. A new state office (Health Systems and Infrastructure Administration [HSIA]) within DHMH’s Public Health Services was established in 2012 that provides oversight and technical support for SHIP. SHIP evaluates progress using 39 measures of health outcomes and health determinants. The Maryland General Assembly also passed a law in 2012 to establish health enterprise zones to invest community health resources in geographic areas with significant health disparities (DHMH SIM Application, 2013).

All-payer hospital rate setting. Through its independent Health Services Cost Review Commission (HSCRC), Maryland is the only state to set its own hospital rates for all public and private payers; a 36-year-old Centers for Medicare & Medicaid Services (CMS) Section 1814(b) Medicare waiver exempted Maryland hospitals from national Medicare payment methodologies, as long as the cumulative increase in Medicare expenditures remained lower than the national rate of growth (DHMH Waiver Proposal, 2013). Maryland secured approval for a modernization of this waiver on January 10, 2014 (Rajkumar et al., 2014). The new waiver limits annual per-capita total hospital cost growth for all payers to a percentage based on growth in the per-capita gross state product and will shift hospital revenue away from fee for service and into global payment models. Several stakeholders commented that, although the waiver and the SIM planning efforts were set up separately and conducted in parallel, the goals of both processes were seen as converging toward the end of the planning period.

Robust data resources. Maryland has a broad array of data resources to use for planning and monitoring, including an all-payer claims database (APCD), HSCRC hospital payment data, and a maturing health information exchange (Chesapeake Regional Information System for our Patients [CRISP]) that offers nearly real-time data from all Maryland acute care and specialty hospitals (DHMH SIM Application, 2013; DHMH Plan, 2014).

Workforce. Relative to other U.S. states, Maryland's per-capita supply of primary care and specialty physicians, and physicians assistants, is above average, and the percentage of the state population living in an area with a shortage of primary care health professionals is below average (SHADAC State Profile, 2012). Maryland has some experience with community health workers (CHWs), but does not have a formal certification process. The market supply of CHWs and the state's training capacity for CHWs was not known at the beginning of the planning process. Similar to other states, Maryland has a nursing shortage, which is projected to increase through 2030 (Jurascheck, 2013).

Political environment supportive of health care reform. Shortly after the Patient Protection and Affordable Care Act (ACA) was passed, Maryland established by executive order a Health Care Reform Coordinating Council, which noted in 2011 that, "While some states have responded with calls for obstruction, Maryland took bold action to build on the reforms already in place and our renowned health care system to develop a national model for the implementation of health reform" (Health Care Reform Coordinating Council, 2011, p.i). A Health Care Delivery Reform Subcommittee with broad representation from the business, provider, and payer communities was authorized in July 2011 to advise the council, help track implementation of reform efforts, and share best practices (Health Care Delivery Reform Subcommittee, 2013).

14.2 Planning Infrastructure and Process

In this section, we describe the state leadership and support for the planning process, the stakeholder groups and meetings that occurred, the role of the stakeholders and the Governor's Office, the perspectives of stakeholders on the state as a convener of health care reform, and additional planning efforts. The planning process began in April 2013. State officials submitted a final Plan to CMS on March 31, 2014. The plan was shared for public comment on the DHMH Web site around the time it was submitted to CMS (DHMH SIM Website, 2014).

State leadership and support. A core team from DHMH provided operational leadership of the planning process, which included the Public Health Services Deputy Secretary, a policy advisor to the Deputy Secretary, and the HSIA Director and Deputy Director. Maryland also engaged a contractor (HQP) as part of its core team to facilitate stakeholder meetings, receive stakeholder feedback, and provide consultation and assistance with writing. Additional

consultants and contractors provided input on aspects of the evolving model or conducted data analyses to fine-tune Plan details.

SIM award funding was used to support contracts with organizations and individuals directly supporting the planning process. Because funds from the SIM award could not be transferred to them quickly, a small amount of state funding was provided to CRISP early in the process to get work started. The state provided in-kind support to the planning process through staff time. The specific amount of support is not known but was estimated as “significant” by state officials.

Stakeholder groups and meetings. Maryland has fine-tuned a stakeholder engagement process, most recently based on their experience with the Medicare waiver modernization process. This process includes involving stakeholders early, casting a wide net, proactively soliciting stakeholders from underrepresented groups, and including a mix of public forums and private discussions with small groups and individuals.

For the SIM Initiative, Maryland created two external stakeholder groups, one for payers and providers and one for LHIC stakeholders, who represented local public health departments; community health, behavioral health, and social service agencies; and nonprovider specialty organizations. Maryland used a public process to solicit individuals and organizations to participate in the groups. They called and emailed specific individuals to cast a wide net geographically and by stakeholder type. A summary of stakeholder groups and meetings is provided in [Table 14-1](#).

Table 14-1. Summary of stakeholder meetings

| Stakeholders | Number of meetings | Timeframe |
|---|--------------------|--------------------------|
| Internal state stakeholders (e.g., state and quasi-state officials; CRISP, MHCC, HSCRC) | 1 | April 2013 |
| Payers and providers (n=28) | 3 | May, June, and July 2013 |
| LHICs (n=29) | 3 | May, June, and July 2013 |
| All stakeholders combined | 1 | September 2013 |

Abbreviations: CRISP= Chesapeake Regional Information Systems for our Patients, HSCRC = Health Services Cost Review Commission, LHIC = Local Health Improvement Coalition, MHCC = Maryland Health Care Commission.

Except for the initial state stakeholder meeting, all meetings were open to the public and facilitated by HQP. Meeting slides and agendas were available on a public Web site, but meeting summaries were not publicly available. All stakeholders said the meetings were well-organized and facilitated, and collegial. However, many stakeholders said that meeting materials

were not available far enough in advance of the meetings to review, reflect on, or share with colleagues.

Role of stakeholders. Stakeholders played an advisory role in the planning process; final decision-making authority rested with the core team of state officials. Nearly all the stakeholders expressed broad agreement about having significant input into and influence on the CIMH model throughout the planning process.

State officials began the process with stakeholders using a “straw man” CIMH proposal that had been included in their SIM award application, because they felt the timeline was too short to work with stakeholders to develop a completely new Plan. This approach was viewed by nonstate officials as the only feasible way to accomplish the task on time.

Stakeholders could submit feedback to HQP about the CIMH model or the planning process via email, phone, and later in the process, a wiki site. State leaders said having a neutral party, such as HQP, to whom feedback could be submitted was important for establishing stakeholder trust. State officials reported also receiving significant feedback directly (not through HQP) from a variety of other stakeholders. The wiki was provided too late in the process to be useful, according to some stakeholders and the core state team; some payer and provider stakeholders felt a wiki was not private enough to provide feedback on payment models, which might include proprietary or business-sensitive information. Between formal meetings, the core team spoke or met with individuals and small groups and contacted specific stakeholders for additional input and to seek buy-in. As one payer said, “I think there was a lot of shaping [of the model] outside of the [formal] meetings.”

No single stakeholder group appeared to be dominant in influencing the model as a whole, according to stakeholders, although the payer/provider stakeholder group played a significant role in the early abandonment of a shared savings approach. Both payer/provider and LHIC stakeholder groups provided input that helped the CHH concept on the community side of CIMH to evolve over the course of stakeholder meetings. The LHIC stakeholders significantly influenced the inclusion of an increased focus on behavioral health.

Missing stakeholders. Multiple stakeholders identified CMS as the most important missing stakeholder and reported difficulty designing multi-payer models without CMS at the table. Other missing stakeholders in Maryland included employer self-funded health plans and the Department of Corrections, which were identified as missing once model details began to be elaborated. Although the stakeholder rosters did include some patient/caregiver representation, several stakeholders commented on the absence of patients’ voices during discussions.

Role of the Governor’s Office. Although the Governor’s Office was not intimately involved in the day-to-day management of the process, executive leadership commitment was

evident, with several interviewees commenting on the support from the Governor, Lieutenant Governor, DHMH Secretary, one of Maryland's U.S. Senators, and several Maryland legislators. The Governor's Office on Health Care Reform consulted frequently with the DHMH core team, and also attended several stakeholder meetings.

The state as convener of health care reform. Overall, interviewees had complimentary views of the state as a convener of the SIM Model Design process. As one provider commented, "The process used did not pit us against each other from a negotiations standpoint; it was more of a collaborative effort." Some interviewees remarked that Maryland is generally viewed as a neutral convener and has "more appetite" for statewide convening relative to other states, notably in its long history of all-payer, all-hospital rate-setting through the HSCRC. Generalizing beyond Maryland, nearly all interviewees commented that the state has to be the convener for health care reform because "who else would do it?" The state is seen as the only entity that has the responsibility, authority, and policy levers to convene the necessary stakeholders and pull off a change as significant and as large as this.

Despite generally favorable views of the process used in Maryland, some provider stakeholders expressed reservations about the state as a convener because of its regulatory role and authority, saying this creates a different dynamic than payers and providers working together, where no one party has regulatory authority over the other.

Additional planning efforts. In addition to stakeholder meetings, the state engaged in several planning efforts to ready the state to implement the CIMH model. This included funding CRISP to further refine and develop prototypes for analytic tools and reporting capabilities, funding MHCC to evaluate readiness of the APCD for performance reporting, funding Optumas Health Care Reform Consulting for actuarial modeling of health care costs and savings under the CIMH model, and funding additional HSCRC data analyses to aid in the selection of priority populations and geographic areas for initial implementation.

14.3 The Maryland Plan

The Plan, as noted, proposes creation of a statewide infrastructure for CIMH.(DHMH Plan, 2014). This model includes increasing statewide provider participation in PCMH-like models to 80 percent, combined with community interventions that address both physical and behavioral health needs and are provided by community health teams coordinated through CHHs. The major policy lever in the Plan is state legislation establishing the CIMH program and advisory board.

14.3.1 Models and Strategies

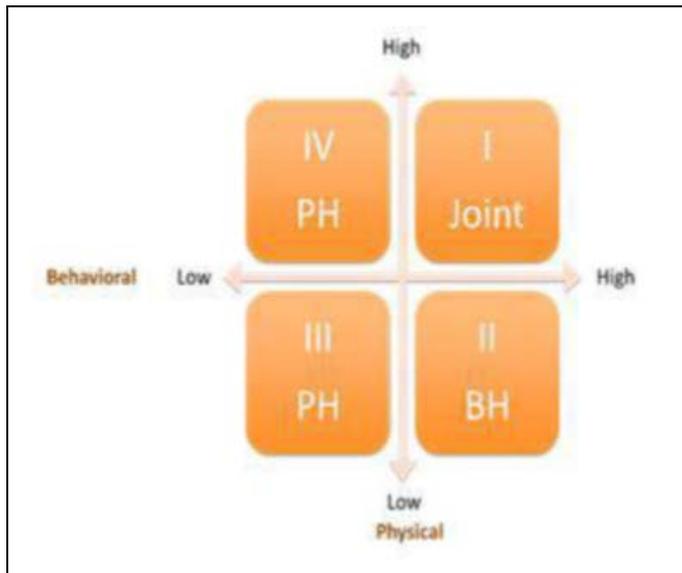
The CIMH model includes five components: the PCMH delivery and payment models, community infrastructure to support community health, workforce development of CHWs, a CIMH public utility for operational support and oversight, and enhanced data analytics and health information technology (health IT) tools to support the model. *Appendix Table 14A-1* provides a summary description of the innovations proposed in each category, initiatives on which they are built, populations they address, policy levers proposed, and implementation entities.

PCMH model. The Plan proposes to have 80 percent of Marylanders receiving primary care in medical home-like settings by providing practices and care-providing organizations flexible pathways to PCMH certification. These pathways would include existing practice participation in a PCMH program (Maryland multi-payer PCMH program or a single payer-sponsored program), participation in an accountable care organization, recognition as a Medicaid chronic health home, recognition as a federally qualified health center (FQHC) advanced primary care practice demonstration site, or school-based health centers with medical home capacities. Practices not already participating in some kind of PCMH program involving fixed PCMH transformation payments or value-based incentives (or both) would be able to be certified as a PCMH for CIMH by meeting minimum state-defined standards, which are designed to be less onerous than external program standards (e.g., National Committee for Quality Assurance) to encourage participation. The state would negotiate with CMS to initiate Medicare fee-for-service (FFS) participation in the existing multipayer PCMH model. Standard quality and cost metrics would be developed for use by all payers, with future funding and payments based on single-payer PCMH payment methodologies after the existing multipayer program sunsets in 2015. All payers are expected to share results of patient attribution and data for care coordination and reporting, and participate in an integrated evaluation. Performance would be evaluated at both the practice and LHIC level to incentivize community coordination.

Infrastructure to support community health. The Plan proposes to provide community-based wraparound services that enhance the medical home so it includes community supports beyond clinical care. This model would adopt major components from HQP's Advanced Preventive Service model to provide community-based interventions and care coordination initially focused on the Medicare FFS and dually eligible beneficiaries. This approach would identify individuals who represent a disproportionate share of health care costs and provide them with structured, intensive, evidence-based community interventions individualized to their needs. These services would include behavioral health and social service assistance to address the complexity of patients' needs.

To integrate behavioral health and primary care, the model plans to use the Clinical Integration model along with the Medicaid Chronic Health Home model and an expanded Behavioral Health in Pediatric Primary Care Program. The Clinical Integration model, outlined in *Figure 14-1*, categorizes patients in four quadrants based on their level of behavioral and physical health needs. Based on their quadrant, patients would be encouraged to participate in various interventions. For example, patients with both high behavioral and high physical health needs fall into category I (joint) and would be encouraged to participate in a Chronic Health Home initiative, whereas those with low to moderate behavioral health and high physical health needs fall into category IV (physical health) and would be encouraged to participate in a PCMH program. Patients would be identified for these interventions either using analytical tools developed by CRISP or by being referred directly from CIMH practices.

Figure 14-1. The Four Quadrants of Clinical Integration



Source: Maryland's State Healthcare Innovation Plan, March 31, 2014

New regional entities called CHHs established throughout the state would identify individuals for services and oversee the provision of community interventions. The state would establish nine to 12 CHHs over the course of 4 years using a procurement process targeted at entities with relevant experience—including LHICs, local health departments, hospitals, community-based 501c3 organizations, and collaborative partnerships. Although LHICs were initially proposed as the entity to serve as the CHHs, stakeholders commented that not all LHICs within the state had the same capacity to take on this role. Funding from a Round 2 Model Test award (or other grant) would be used to finance CHH startup and operations over the first several years of the initiative. Funding for later years would come from payers opting to participate in the intervention. CIMH participating practices would be required to provide clinical care coordination for identified patients either through CHTs within CHH or by choosing to use funds to offset the costs of paying for practice-based coordinator or CHW staff.

Workforce development. The main workforce development strategy in the Plan is development of the role of CHWs. Although nurses might be required for provision of some community interventions through the CHH, use of CHWs might be feasible for some services, according to the Plan. In addition, CHWs might help facilitate enrollment for community

interventions among high-risk individuals within geographic “hot spots” (i.e., areas with high costs, poor health or both).

CIMH public utility. The state would create a new public utility to configure the resources and skills needed to govern and manage the CIMH model. This utility would be responsible for practice and CHH certification, practice- and LHIC-level performance reporting and bonus allocation, funds disbursement, and overall CIMH oversight and monitoring. Two existing entities (MHCC and HSIA within DHMH) were identified to lead the utility, which would also include a CIMH advisory board, an operational management system, and a learning system. The learning system would provide ongoing, rapid-cycle evaluation to assess performance within the CIMH framework and identify promising practices and positive impact on health care cost. Learning collaboratives would be implemented to disseminate the learning system’s best practices and data analyses. In turn, the CIMH program, as well as participating organizations, would be expected to use the learning system to inform practice changes and enhance overall program performance. Financial support for the public utility is planned to come initially come from a Round 2 Model Test award. After the infrastructure is established and the model is achieving results, user fees from payers would support ongoing infrastructure and operations.

Strategic use of data and health IT. The state proposes expanding several existing data systems, including the APCD and CRISP, to support both the practice and community side of CIMH. Enhancements to the APCD would provide practitioner- and LHIC-level performance reporting as part of the CIMH operational management system, and also serve needs related to the CIMH learning system for model performance monitoring and evaluation. The Plan also includes integration of CRISP’s Encounter Notification System into the CIMH operational management system, and proposes CIMH practice participation criteria to include use of the notification system. Prototype tools for identifying geographic hot spots were further refined by CRISP during the planning period, for use to identify communities in need of more intensive outreach and services.

Other models and strategies considered but rejected from the Plan. Overall, the CIMH model proposed in Maryland’s SIM award application was the only model considered by stakeholders. A shared savings approach for financing the CHHs was initially proposed, but payer and provider stakeholders expressed concern about the long-term sustainability of that approach given the likelihood of diminishing savings over time. Also, payers felt it would be challenging for the CIMH to calculate net shared savings attributable to the model in the wake of the multiple statewide health care reforms being implemented. Stakeholders commented on the need to fund the public utility and CHHs with “real” dollars from Day 1, in order to support and sustain the required infrastructure. At the same time, they said that shared savings may remain a feature of single-payer medical home models.

14.3.2 Policy Levers

Existing and proposed policy levers for Plan implementation are listed in [Appendix Table 14A-1](#). A key policy lever is the 2014 Community Integrated Medical Home Program bill, passed April 5, 2014, which establishes the CIMH program and an advisory board. A more comprehensive CIMH bill is planned prior to the expiration of the 2010 legislation authorizing the existing multipayer PCMH program. The state has broad authority under the existing legislation to standardize metrics and attribution methodologies, which will continue to be developed and refined through the CIMH Public Utility. Existing and future single carrier programs are to be aligned using these standards. Medicare participation would be sought through additional waiver authority to enable Medicare to participate in the existing multi-payer PCMH program and by deeming practices participating in Medicare Accountable Care Organizations (ACOs) as CIMH practices.

On the community side of CIMH, the state plans to initially rely on voluntary participation by payers other than Medicare with an initial goal of State Employee Health Plan payers. Payers that choose to participate during the first 3 years are to have fees for community interventions paid for using Round 2 Model Test award funding (if received) and to assume financial responsibility beginning in year 4. Payers that choose not to participate in the first two years would have to agree to participate starting in year 3, at their own cost, if their performance during the first two years failed to meet established benchmarks. Although not specifically designed as a component of the Plan, and not discussed in any measurable way during formal stakeholder meetings, the Plan considers the recently approved Medicare waiver a major lever for encouraging health care provider and hospital delivery system participation in the community side of CIMH. As one provider stakeholder commented, hospitals have a much larger financial incentive to keep people healthy and out of the hospital under the new waiver, and would be happy to have services and resources to help them do that through a CHH.

14.3.3 Intended Impact of the Plan

The Plan builds on existing initiatives and infrastructure to reduce health disparities, prevent avoidable complications of complex chronic disease, and control health care costs. The practice side of CIMH is designed to increase participation from current levels to a level such that 80 percent of Marylanders receive care within a PCMH practice by the end of 4 years. Although the impact of PCMH on any one person would be small, according to the Plan, applied over many people the population health impact could be important. In contrast, CHHs would provide community interventions to a relatively small proportion of the population, with the realistic expectation that only about half of targeted participants would choose to actively participate in services. However, because these targeted populations represent a disproportionate share of avoidable health care use and cost, the Plan is expected to have a greater likelihood of providing a return on investment to allow for long-term sustainability.

14.3.4 Proposed Next Steps

The state intends to submit a Round 2 SIM Model Test application to implement the Plan. Also, based on HB 1235 requirements, the state is to create and submit a more detailed CIMH implementation plan to the Maryland legislature by October 2015. The draft Plan provides a high-level timeline for implementation, using a phased approach over 4 years, consistent with stakeholder input that a change this large cannot be rolled out statewide on Day 1. The previously described CIMH public utility would provide overall governance. Nearly all stakeholders (both internal and external to the state government) commented that the state would try to implement the Plan even without a Round 2 award. However, most commented that the implementation would be on a much smaller scale and over a longer period. One state official said that with or without a Round 2 award, they would use the Plan as the “North Star” for aligning state efforts, in terms of both state general dollars and federal funds for supporting the Plan.

14.4 Discussion

The SIM Model Design process in Maryland resulted in a Plan that aligns existing programs and initiatives and leverages existing state and community resources—including the state’s experience with PCMH, its leadership with respect to health care reform, and its existing data resources and capabilities. Few “new” lessons were learned by the state from the process, but balancing the timeline available with the goal of widespread and collaborative stakeholder engagement was managed through use of an initial straw man proposal and a relatively small number of public forums, combined with additional private discussions with selected stakeholders.

Most stakeholders thought the practice side of CIMH was feasible, but that the community side of CIMH would depend on a Round 2 Model Test award for initial start-up and operations. Despite stakeholder agreement regarding an effective Model Design facilitation by the state, the state did not get the initial voluntary cooperation of all payers in CIMH. Providers and commercial payers wanted to see operational details addressing concerns over duplication of services and adequate workforce in addition to demonstrated value, before agreeing to participate.

14.4.1 Critical Factors Shaping the Plan

Three critical factors were identified as shaping the Plan: (1) state and commercial payer experience with PCMH models, (2) Model Design leadership organizationally placed within DHMH Public Health Services and supported by senior leadership, and (3) HQP experience with community interventions combined with Maryland’s existing data resources and capabilities.

The state reportedly had the most influence over the model selected for the Plan, as it proposed CIMH in its SIM Model Design Application and presented it as the straw man during initial stakeholder meetings. The state’s experience with multi-payer PCMH was considered a likely factor in the selection of PCMH as the main component of the practice side of the CIMH. Early in the Model Design process, state stakeholders recognized the importance to providers and payers of preserving existing contractual relationships; so, rather than propose a completely new PCMH model, they offered multiple entry points, including existing PCMH programs for the practice side of CIMH.

Situating leadership of the SIM application and subsequent planning process in DHMH Public Health Services implied an early desire to build on LHIC capacity to support the existing State Health Improvement Process . As one local public health stakeholder commented, this was the first stakeholder effort for which the public health sector and the community had been invited to the table as equal partners with health care payers and providers, which proved critical for development of the CHH concept. Further, members of the core state SIM team had experience outside traditional public health, and were strongly supported by the Secretary, which helped mobilize a broad range of stakeholders throughout the state.

The community side of CIMH was the least specified component at the outset of the planning process, yet the state’s existing data resources and CRISP capabilities provided fertile ground for development. Although the state had some notion of identifying geographic hot spots using data and new analytic tools in collaboration with LHICs and health enterprise zones, the Model Design process further developed these ideas. HQP’s experience with their Advanced Preventive Service model was presented as a straw man that could be adapted for Maryland. Given its direct experience, HQP was viewed by the state and other stakeholders as a credible authority for providing input into the design of the community side of CIMH. So, with general agreement about using a similar model, prototype tools developed by CRISP and iterative data analyses provided the SIM core team and stakeholders with concrete examples of how the community side could be put into operation. Towards the end of the planning period, stakeholders commented on increasing synergy with the Medicare waiver proposal. A payer stakeholder commented that a “major community care expansion is almost necessary for us to meet the various trip wires on the [new] waiver.”

14.4.2 Lessons Learned

The Model Design process in Maryland yields several lessons, according to stakeholders, some of which were not necessarily new to the state but confirmed what had been known before the process began.

- **The timeline available ultimately dictates the process used.** Multiple stakeholders commented that stakeholder engagement needs to be meaningful and not just for “rubber stamping” what the state proposes. However, they noted that true

engagement takes time and the aggressive timeline (originally 6 months) for developing a plan of this scale was felt to be at odds with the goal of true engagement. Because of the timeline, nearly all stakeholders agreed that the process needed to start with a straw man proposal. Some stakeholders would have liked smaller workgroups of stakeholders meeting more frequently to hammer out details, or to brainstorm truly innovative models. However, a process requiring intense participation by stakeholders was not considered feasible by most, particularly in the context of other aspects of ACA implementation, which as one nonstate stakeholder commented, “is sucking all of the oxygen out of the room and everyone is running flat out going to a dozen meetings....” As a result of the short timeline, state stakeholders said they selected an approach that presented enough of a framework to solicit reactions, but not overly detailed to suggest a “done deal.”

- **Cast a wide net when identifying stakeholders and ensure the process taps into stakeholder areas of expertise, whether in public or private forums.** The deliberative process was seen as facilitated by involving stakeholders early, reaching out to as many diverse stakeholders as possible, and avoiding a mere “coalition of the willing.” Several non-payer stakeholders commented on how useful payer perspectives were with respect to managing populations. Others commented on how the process allowed them to appreciate the diversity of what is happening in the state with respect to innovative reforms. Although a public and transparent process was considered essential, stakeholders commented that private discussions with stakeholders outside formal meetings were needed to gauge level of buy-in and get candid feedback on sensitive areas of the models, such as payment.
- **Strategic communication about the model may avoid confusion.** Several stakeholders noted that quite a bit of time both in and outside formal stakeholder meetings was spent going over the CIMH concept, bringing stakeholders up to speed, and answering the “what are we trying to do?” question. Individuals accustomed to working in traditional public health and in the community were not familiar with health care delivery and payment innovations; likewise, individuals on the health care side were not as familiar with the array of services and resources available within the community. While some interviewees appreciated the additional time spent reviewing the basics, others felt that this took time away from having detailed discussions of various aspects of the model. Thus, state stakeholders commented that more tailored or strategic communication about the CIMH model early on might have avoided missed opportunities for discussion during meetings.
- **Data systems and infrastructure are critical.** Several stakeholders commented on Maryland’s strengths with respect to data systems and infrastructure, yet they noted that these systems as currently operating will not support the proposed CIMH model without further investments and development. As one stakeholder commented, “You’ve got to design the jets as you design the engine as you design the airplane to power this thing. We’ve got to be designing this infrastructure so that when you go to fly it, the data engine’s there... To start from scratch, in the test phase? It would be too daunting.”

14.4.3 Potential for Implementation

All stakeholders consider the proposed CIMH model as mostly feasible to implement, but the LHIC stakeholders expressed more enthusiasm and support for CIMH than did the payer/provider stakeholders. The practice side of CIMH was viewed as an extension of what is already happening, so little concern was expressed over feasibility. However, since smaller practices were not well-represented in the payers/providers stakeholder group, the feasibility of reaching these practices, many of which are not currently participating in such models, is not known.

Most stakeholders thought the community side of CIMH would be feasible to implement, provided there was adequate funding for start-up and careful attention to ensure adequate staffing and avoid duplication of services. Although the community interventions to be delivered by CHHs are not necessarily new, the statewide infrastructure for providing them is new. Most stakeholders agreed that the infrastructure necessary would not be feasible to implement without a Round 2 Model Test award. One payer and one provider stakeholder expressed concerns about handing off beneficiaries to CHHs to receive community interventions, and yet still having the financial risk and responsibility for the patient and the quality of services provided. Although LHIC stakeholders clearly saw payer- or provider-delivered case-management services as distinct from what a CHH would deliver, payer and provider stakeholders did not always share that view. Commercial payers wanted some evidence that the model would add value before agreeing to participate. In addition to concerns over duplication of services, several stakeholders identified having the necessary CHWs and nursing workforce to support statewide roll-out as a challenge.

State stakeholders expressed some concerns about losing momentum with stakeholders between turning in the Plan at the end of the Model Design period and the start of a Model Test award. However, most stakeholders said the Plan would be implemented with or without an award because of the strong support for health care reform by the state, specifically the DHMH Secretary. Most stakeholders acknowledged that speed of implementation would be significantly slower, particularly on the community side, without a Round 2 Model Test award.

14.4.4 Applicability to Other States

Maryland has a history of payer and provider engagement with respect to hospital rate-setting and to PCMH models, and the SIM Model Design process came on the heels of the Medicare waiver modernization proposal. Thus, the payer and provider stakeholders may have been primed for Model Design discussions that involved a statewide approach. Maryland's CIMH model builds on years of investment in advanced data and analytics capacity, so other states may need to invest in similar data infrastructure to support a similar model, according to interviewees. Although data infrastructure and experience with innovative models can facilitate the Model Design process, stakeholders noted that a critical mass of health care reform

champions at various levels of leadership within the state, payer, and provider communities is needed to design and implement something of this scale.

14.4.5 Limitations of This Evaluation

Because we conducted all stakeholder interviews before the state submitted its final Plan, the stakeholder comments reported here may not accurately reflect opinion of the final Plan. In addition, several payer stakeholders declined to participate in interviews for this case study, and the consumer perspective was represented by organizations that advocate on behalf of consumers and patients, rather than by individuals.

14.5 References

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Appendix Table 14A-1. Models and strategies proposed in Maryland Health Care Innovation Plan

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|---|---|---------------------------|---|---|
| <p>PCMH model Practice side of CIMH Provide fixed PCMH transformation payments, value-based payments, or both for practices (and other care-providing organizations) meeting state-defined PCMH criteria</p> | <p>State-led multi-payer PCMH pilot program (Aetna, CareFirst, Cigna, Medicaid, Tricare, United) Single-payer PCMH programs (CareFirst and Cigna) Medicaid Chronic Health Homes FQHC Advanced Primary Care Practice Demonstration Medicare ACOs Medicaid MCO PCMH-like programs</p> | <p>General population</p> | <p>Existing *Health General 19-1A-03 (“Multipayer PCMH Pilot”) signed into law April 13, 2010. Broad authority under this law to standardize metrics and attribution methodologies. Federal Demonstration Award—FQHC Advanced Primary Care Practice ACA-related state plan amendment— Medicaid Chronic Health Home Program Health General 19-706 and Insurance 15-1801-1803 (Health Insurance - Clinically Integrated Organizations) signed into law May 20, 2010</p> <p>Proposed state legislative actions *Community Integrated Medical Home Program bill (HB 1235) established the Community Integrated Medical Home Program and Advisory Board, first stage passed April 5, 2014.</p> <p>Proposed executive branch actions Purchasing contracts for state employee health plan</p> <p>Proposed federal action *Additional waiver authority for Medicare participation in the existing multipayer PCMH program Round 2 Model Test SIM Award</p> <p>Proposed state facilitation of system change Integrated learning system that includes training and peer support from other practices</p> | <p>New CIMH public utility MHCC Medicare FFS Medicare ACOs Primary care practices, including FQHC advanced primary care demonstration sites Medicaid chronic health homes</p> |

(continued)

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Appendix Table 14A-1. Models and strategies proposed in Maryland Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|--|--|---|--|--|
| Infrastructure to support community health Community side of CIMH Provides community-based interventions to targeted patient populations through new CHH entities | Builds on LHIC infrastructure as part of the SHIP Utilizes HQP’s Advanced Preventive Services clinical care coordination model and the Hennepin County’s Hennepin Health model for safety-net populations | Medicare FFS and dually eligible beneficiaries (initial target) Will expand to include adults in addition to youth | Existing *Maryland Health Progress Act 2012 (establishes grant-making authority for the DHMH Secretary) *Medicare Waiver Modernization, approved January 10, 2014 Maryland Health Improvement and Disparities Reduction Act of 2012, signed into law April 10, 2012 (Created health enterprise zones) Community Partnership Assistance program established in 2014 to provide funding to hospitals for community partnerships | New CIMH public utility DHMH HSIA LHICs Local health departments 501c3 organizations Health enterprise zones CIMH-recognized practices Medicare FFS (initially) State Employee Health Plan Other payers |
| Behavioral Health Integration with Primary Care | Behavioral Health in Pediatrics Program | | Potential state legislative actions To be determined Potential state regulatory actions Privacy and security standards for sharing data with CHHs Proposed executive branch actions *Purchasing contracts for state employee health plan Proposed federal action *Round 2 Model Test SIM Award Proposed state facilitation of system change *Other payer participation through a model where payers agree to participate after 2 years if payer performance does not meet established benchmarks | |

(continued)

Appendix Table 14A-1. Models and strategies proposed in Maryland Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|---|--|---|---|---|
| Workforce development Statewide standardized training for CHWs | Health Enterprise Zones J-CHIP (program operated through Johns Hopkins University Hospital) | Will train CHWs to provide services to target populations via CHH in the CIMH model | Existing Maryland Health Improvement and Disparities Reduction Act of 2012, signed into law April 10, 2012 (Created health enterprise zones). Proposed state legislative actions Several bills have been proposed to create CHW advisory body to standardize education and training requirements and license CHWs to develop reimbursement models. | New CHW Advisory Board DHMH LHICs Local health departments 501c3 organizations Health enterprise zones and their grantees CHW training entities, specifically Maryland community colleges |
| CIMH public utility Provides oversight and management of the CIMH model | Builds on existing MHCC and HSIA functions and responsibilities. | N/A | Proposed state legislative actions *Community Integrated Medical Home Program bill (HB 1235) established the Community Integrated Medical Home Program and Advisory Board, first stage passed April 5, 2014. | DHMH HSIA MHCC |

(continued)

Appendix Table 14A-1. Models and strategies proposed in Maryland Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|---|--|--|---|---|
| Enhanced data analysis and Health IT Enhancements to the APCD to support CIMH operational management system and learning management system HIE enhancements to support CIMH operational management system and learning management system | State APCD (“Medical Care Data Base”) State Health Information Exchange (“CRISP”) | | Existing House Bill 800 (reauthorization and expansion of the APCD) signed into law in 2007. MHCC Medicare research data use agreement ONC (State HIE Cooperative Agreement, Regional Extension Center Cooperative Agreement, HIE Challenge Program) CRISP start-up funding provided by HSCRC Proposed executive branch actions Submit for Medicare “qualified entity” status Proposed state regulatory actions Establish and align data privacy and security policies to support the CIMH (in process) Proposed federal action Approve “qualified entity” status Round 2 Model Test SIM Award | New CIMH public utility MHCC HSCRC CRISP DHMH State Attorney General |
| Public health data enhancements | Prior work conducted by Department of Health and Human Services and seven states | Patients enrolled in multiple health and social service programs | | |
| Unified patient consent form | | | | |

¹Policy levers include Medicaid waivers; federal grants (including Round 2 SIM award); state laws; state regulations; state investments (e.g., in public health programming); foundation grants; employer-led coalitions to drive change among providers, purchasers, or plans; state government-led coalitions, task forces, or commissions to drive voluntary change among providers, purchasers, or plans; state purchasing contracts; and state-level (Governor-initiated) executive policy directives.

Abbreviations: ACA = Affordable Care Act, ACO = accountable care organizations, APCD = all-payer claims database, CHH = community health hub, CHW = community health worker, CIMH = community-integrated medical home, CRISP = Chesapeake Regional Information Systems for our Patients, DHMH = Department of Health and Mental Hygiene, FFS = fee for service, FQHC = federally qualified health center, HIE = health information exchange, HSCRC = Health Services Cost Review Commission, HSIA = Health Systems and Infrastructure Administration, LHIC = local health improvement coalition, MCO = managed care organization, MHCC = Maryland Health Care Commission, N/A = not applicable, OMS = Operational Management System, ONC = Office of the National Coordinator for Health IT, PCMH = patient-centered medical home, SHIP = state health improvement process, SIM= State Innovation Model.

15. Michigan

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Michigan’s Health Care Innovation Plan (the Plan), called the Blueprint for Health Innovation, builds on existing initiatives under way in the state. In particular, the Plan extends the existing Michigan Primary Care Transformation Initiative (MiPCT), one of the country’s largest multi-payer patient-centered medical home (PCMH) demonstrations. The Plan also aims to promote clinical integration and provider accountability by seeking health plans and provider organizations to voluntarily test new payment models through Accountable Systems of Care (ASC), which are similar to Accountable Care Organizations (ACOs). The Michigan Association of Health Plans has written to the state formally opposing this aspect of the Plan; however, one state official said four health plans have contacted the state expressing interest in piloting ASC contracts. The Plan also calls for recognizing cross-sector consortia of organizations as community health innovation regions (CHIRs), which would be charged with improving overall population health using local approaches and organizations. In addition, the state would make investments in new and existing data systems.

The Michigan Department of Community Health (MDCH) led the planning process, with Governor’s Office support, which was managed primarily through three committees, one of which consisted of invited external stakeholders. The state also held three focus groups midway through the process, to enable feedback from additional stakeholders, followed by five public “town hall” meetings around the state. Most stakeholders were well represented, with the reported exception of large employers (which became involved somewhat late in the process) and tribal organizations (which were invited to participate, though unsuccessfully because of problems finding representation satisfactory to all Michigan tribes).

The state’s strategies will be implemented through a combination of regulations, updated contracts with Medicaid managed care plans, a Medicaid section 1115 waiver or state plan amendment, and voluntary participation by private payers in MiPCT. The Plan anticipates most people in three pilot communities will be in a PCMH and enrolled in a non-fee for service (FFS) payment model by the end of 2017, and most people statewide enrolled in a non-FFS model and benefiting from a local CHIR by the end of 2019.

15.1 Context for Health Care Innovation

Several contextual factors in Michigan helped shape the Plan. The most important is one of the country’s largest multi-payer PCMH demonstrations, MiPCT, which includes participation from Medicaid, Blue Cross Blue Shield of Michigan, Blue Care Network (a health maintenance

organization), Priority Health, and Medicare (through the Centers for Medicare & Medicaid Services [CMS] Multi-payer Advanced Primary Care Practice Demonstration). Nearly 400 practices are participating in the MiPCT and over 1,200 have met Blue Cross Blue Shield of Michigan's PCMH practice recognition criteria. MiPCT practices now benefit from a multi-payer claims database established to provide practices with data as part of this demonstration.

A driving force behind MiPCT has been Blue Cross Blue Shield of Michigan, which insures 69 percent of the state's commercial health insurance market (Daly, 2012). Blue Cross, in turn, contracts with Michigan-specific entities called Physician Organizations, which are regional organizations such as integrated delivery networks; physician hospital organizations; and independent practice associations that represent groups of physicians, administer quality improvement initiatives, and distribute incentive payments from payers to participating practices.

Another important contextual factor is the strong reliance on managed care in Michigan's Medicaid program. Nearly 90 percent of Medicaid beneficiaries in Michigan are enrolled in managed care plans (Kaiser Family Foundation, 2013), including some who are dually eligible for Medicaid and Medicare. The state is in the process of negotiating a memorandum of understanding with CMS to allow it to move dually eligible beneficiaries who choose to participate in a four-region state demonstration project into new organizations called Integrated Care Organizations. These organizations will provide all physical health care, long-term services and supports, and pharmacy services to dually eligible patients and coordinate with Prepaid Inpatient Health Plans to ensure coverage of behavioral health services. Further, when the state expanded its Medicaid program under the Patient Protection and Affordable Care Act, it introduced payment mechanisms aimed at incentivizing judicious use of health care by patients through the use of cost-sharing and health savings accounts for the expansion populations (Ayanian, 2013). Several interviewees also said that some of the country's preeminent thinkers in value-based insurance design are based in Michigan.

The state has several active local consortia of organizations serving as federal Chartered Value Exchanges and participating in the Robert Wood Johnson Foundation's Aligning Forces for Quality. In addition, three communities are receiving funding from CMS through Health Care Innovation Awards to test a "Pathways Community Hub" model, through which community health workers help patients navigate the health care system and encourage them to see their primary care provider regularly, connect patients with social services in the community, and engage in care coordination. Efforts in these three communities are being led by the MDCH and the main contractor leading the Plan development process (CMS, 2012).

As in many other parts of the country, the ACO model is beginning to take hold in Michigan. Seventeen Michigan groups have gained approval to operate as ACOs in the Medicare Shared Savings Program, and two additional groups operate as Pioneer ACOs. In addition, Blue Cross is supporting development of ACO-like entities it calls Organized Systems of Care

throughout the state. The University of Michigan’s health system is also an influential player in the state’s health care landscape, based on its reputation as one of the country’s top universities and one of the first organizations to implement the ACO model as part of the influential Medicare Physician Group Practice Demonstration.

Many interviewees felt the state’s political situation was such that it would not have been receptive to radical health policy reform proposals—with some giving this as a reason for the state staff leading the Model Design planning to hew more closely to familiar policy models that already had broad support and represented more incremental changes to the state’s health care delivery landscape.

15.2 Planning Infrastructure and Process

The Michigan Department of Community Health (MDCH) led the planning process, with the support of the Governor’s Office and technical and operational assistance from contractors: the Michigan Public Health Institute and its subcontractors, Public Sector Consultants, Health Management Associates, and Population Health Partners. The process was led by a small planning team, which was overseen by a management team made up of state officials and given input and feedback by a larger advisory committee.

Management and governance approach. The state managed the Plan development process primarily through three committees: (1) a planning team of staff from MDCH and contractors that met weekly to work on the main day-to-day Plan development tasks and operations; (2) a management team of leaders from MDCH departments and the Governor’s Office, who were briefed every 2 weeks by the planning team and made key policy decisions regarding the Plan; and (3) an invitation-only advisory committee of 30 external stakeholders that met every 3 weeks from April to September to provide the planning team with input. The advisory committee was also reconvened in December to review the state’s draft Plan. Advisory committee members represented the leadership of a variety of health care stakeholders—such as insurance companies, business associations, other state agencies (human services and education), health care systems, provider associations, community mental health services providers, long-term care providers, community health alliances, consumer organizations, academic medical institutions, and local public health agencies. Although the advisory committee had no formal voting process, professional meeting facilitators to identify consensus wherever possible.

The advisory committee was frequently broken out into work groups, which included both advisory committee members and other experts who were either invited by, or proactively approached, the state about participating. Separate work groups were established to provide the state with feedback on the ASC model, care coordination, health information systems and health information technology (health IT), and health workforce issues. A fifth work group on payment models was considered initially, but not implemented. Advisory committee meetings tapered off

after the summer months, as the state shifted to seeking one-on-one input from subject matter experts outside the advisory committee membership in the final months of Plan development.

In addition to the advisory committee, the state sought input on preexisting initiatives and potential components of the Plan through a series of three focus groups held in June 2013. These focus groups gathered input on three issues, respectively: primary care transformation, systems of care, and cross-sector partnerships. The focus groups gave additional stakeholders outside the advisory committee—representing payers, delivery systems, provider associations, and organizations that work on improving care quality, as well as community organizations and public health—a chance to inform the state about current initiatives in Michigan that related to the state’s Model Design goals early in the process.

In September and October, five public outreach events or “town hall” meetings were organized in different geographic regions of the state. The state used these meetings to inform and get feedback (in person and electronically afterward) about the delivery and payment reforms the state was contemplating including in the Plan. According to a state official, these meetings lasted about 2 hours, with almost three-fourths of the time devoted to feedback from the public and a question-and-answer session.

Stakeholders’ views of the Model Design process. The stakeholders invited to participate in the planning felt the process was open and communication between the various committees adequate. In fact, the act of bringing people together and having an exchange of ideas among people who do not normally interact was viewed as a major benefit. Most people also felt that having the state government, as opposed to some other entity, convene these discussions around health system reform worked well. Interviewees said participants were generally engaged and collegial during meetings, and were comfortable voicing contrary opinions and engaging in healthy debates. The liveliest and most ongoing debate appears to have emerged between proponents and opponents of the ASC model.

Although stakeholders from the advisory committee praised the state for providing them with multiple means of obtaining information and offering feedback about Plan development, some interviewees felt the advisory committee would have benefited from the participation of large self-insured employers, tribal organizations, and more consumer advocacy organizations. While business associations were members of the advisory committee, specific employers were not. When, partway through the Plan development process, a participating payer recommended including specific employers and purchasers (because these groups drive payer decisions), the planning team reached out to the Automotive Industry Advisory Group and presented at one of their meetings to gather their feedback. One participant from this meeting—which occurred in November, near the end of the state’s Model Design period—expressed disappointment at being left out of the initial planning stage and felt unable to meaningfully contribute to the development of the Plan. A state official said that planning team members have remained in

touch with this employer group, and subsequent meetings are to be held as the Model Test proposal is developed. A state official has also reported that employers attended regional outreach meetings—and some of them provided extensive feedback. Other stakeholders said they thought the state might have come up with a different approach related to ACOs, if employers had been involved in the process from the beginning.

Lack of participation by tribal representatives was the result of different factors. First, the Inter-Tribal Council, Inc. was invited to participate in the Plan development process, but did not respond to the invitation. Then, a representative of the planning team attended a meeting of the Inter-Tribal Council Health Directors to present the SIM opportunity and invite further participation. State stakeholders said they soon learned it was politically infeasible to identify a single tribe to represent all of Michigan’s American Indians in the Plan development process, or to give seats on the advisory committee to representatives from each tribe—eventually resulting in no tribal representation at the table, or in our evaluation interviews. State staff said they would continue to reach out to American Indian Tribes.

Stakeholders gave the state mixed reviews for their efforts to incorporate stakeholder feedback into the Plan. Stakeholders whose ideas were adopted praised the state for its open-mindedness and responsiveness, but those whose objections to certain Plan components were overruled had the opposite opinion. Stakeholders also had mixed views about building the Plan off existing initiatives; some felt this was an advantage because it took into account “facts on the ground,” whereas others were disappointed the state did not propose something more “innovative.” Many stakeholders wished the state had allowed the advisory committee to help develop the new payment models proposed in the Plan earlier in the planning process—instead of waiting until the end, when two of the final meetings of the Advisory Committee were devoted to payment models.

Nearly all involved thought the 8-month period for the Model Design process was too short, especially because half of it occurred during summer months when people often were unavailable because of vacations. But one interviewee thought the short duration was an advantage because it would be harder to get important, busy individuals to commit to a planning process spread over a longer period. Overall, stakeholders were pleased to have been a part of developing the Plan and felt that its development could not have occurred in the absence of the Model Design award.

15.3 The Michigan Plan

The Plan extends the existing MiPCT multi-payer PCMH initiative and builds on existing public and private integration efforts by encouraging Medicaid managed care plans to enter into contracts with ASCs (Snyder, 2014). The Plan also calls for recognizing cross-sector consortia of organizations as CHIRs, which would be charged with improving overall population health using

local approaches and organizations and a “collective impact” model. In addition, the state would invest in new and existing data systems. The state would also explore creating a registry of community health workers, who are being deployed in many settings and programs—one of which is the Pathways Community Hub currently funded by CMS through a Health Care Innovation Award. The state would implement the Plan through a combination of a Round 2 Model Test award, regulations, updated contracts with Medicaid managed care plans, a Medicaid section 1115 waiver or state plan amendment, and voluntary encouragement of private payer contracts with ASCs.

Michigan proposes to implement the Plan in three yet-to-be-named communities from 2015 to 2017, before scaling up successful elements statewide beginning in 2018. By the end of 2019, Michigan expects a “preponderance” of the state’s population to be enrolled in a non-fee-for-service payment model and will benefit from population-level strategies of a local CHIR; the Plan did not define “preponderance” as any specific percentage of the population.

15.3.1 Models and Strategies

Descriptions of each of the models and strategies constituting the Michigan Plan follow. [Appendix Table 15A-1](#) provides a tabular summary of Plan strategies, initiatives on which they are built, populations they address, policy levers proposed, and implementation entities.

Patient-centered medical homes. The state plans to review the results of MiPCT when they are available in 2015 and, if warranted, extend this demonstration. Practices in this demonstration receive practice transformation payments that range from \$1.50 to \$2.00 per member per month (PMPM), depending on the payer. In addition, Physician Organizations receive care coordination payments ranging from \$3.00 to \$4.50 PMPM to cover the cost of hiring care managers for their practices. Payers also contribute \$0.26 PMPM to a pay-for-performance incentive pool, which is then distributed to Physician Organizations whose practices perform highly on specified quality measures (at least 80 percent of these incentives must be passed along to practices) (McCall et al., forthcoming). If MiPCT is extended, the state would seek additional payers and begin risk-adjusting monthly payments. The Plan does not explicitly state what would happen if the MiPCT evaluation did not produce findings that warranted an expansion of the demonstration.

Accountable care organizations. In 2015, the state plans to recruit Medicaid managed care plans (and encourage other payers) in the three yet-to-be-chosen pilot regions to contract with ASCs. ASCs are a Michigan-specific concept that is similar to ACOs; Level I ASCs would be paid using a shared savings approach with no downside risk; Level II ASCs would be paid using partial capitation and/or condition-specific global capitation approaches. The shared savings model—and the distinction between ‘Level I ASC’ and ‘Level II ASC’—were added based on stakeholder concern that many provider groups were not ready to bear downside risk.

ASCs would be responsible for integrating clinical care across settings, improving performance on quality measures and patient experience, and lowering costs for a defined population, and would be expected to help practices adopt the PCMH model if they had not already done so. ASC performance measures would initially draw on those developed as part of the MiPCT demonstration; however, a multistakeholder Performance and Recognition Committee would be established to ensure ongoing stakeholder representation in development of multi-payer performance metrics. ASCs would be required to obtain agreement from patients to participate in their ASC; and patients already participating in other specialized programs or demonstrations, such as dually eligible beneficiaries, would be excluded from ASCs. Every ASC would be required to serve the same proportion of Medicaid beneficiaries as are in their local geographic service area.

Proponents of ASCs said this model would reduce administrative complexity for practices, which currently must keep track of different payers' PCMH recognition criteria, patient attribution approaches, quality measures, risk-sharing models, and infrastructure supports like plan-sponsored care managers. As one provider explained, "it's hard enough to do this stuff once, but then I have to remember, 'Oh, this person is under the MiPCT demo so I can send a nurse out to their home to do some work.' "

Meanwhile, ASC opponents—primarily the Michigan Association of Health Plans (which represents Medicaid managed care plans, among others) and the Michigan Primary Care Association (an association of federally qualified health centers [FQHCs])—argued that ASCs would introduce a redundant layer of bureaucracy (and costs) between managed care plans and providers, and have written a letter to the state formally opposing this aspect of the Plan (Murdock and Sibilsky, 2013). The planning team responded to this concern by incorporating the two levels of ASC. This satisfied the FQHC association, which now supports the Plan. But some interviewees said that managed care plans already engage in many ASC-like activities and are already paid on a capitation basis (as Level II ASCs could choose to be). The state has explicitly noted that managed care plans could qualify to function as ASCs, but whether such plans would opt to do so remains unclear. Managed care plans and the FQHC association also expressed in their letter that ASCs should be required to be licensed health plans and, as such, maintain sufficient capital reserves to cover cost overruns incurred in the course of paying for their patients' care (Murdock and Sibilsky, 2013).

Infrastructure for population health. In 2015, the state would require ASCs in the three pilot regions to participate in community-based population health efforts through community health innovation regions CHIRs. These new entities are to be consortia of cross-sector community organizations supported by a "backbone" organization with a small number of paid staff and would be located within—but not necessarily correspond with the exact boundaries of—Michigan's Prosperity Regions (which are previously defined geographic areas

eligible for state-funded economic development grants). CHIRs are to leverage health department accreditation as well as hospital community benefits requirements to organize a collaborative community health needs assessment that identifies health concerns in their area and the root causes of poor health, and to prioritize and champion strategic evidence-based interventions. Each CHIR would facilitate development of an action plan that organizes and aligns community partners to maximize collective impact and help providers integrate clinical, behavioral, and social services. Several interviewees described CHIRs' primary charge as addressing the social determinants of health, although this is one among several purposes articulated in the Plan. CHIRs were also described as promoting a 'health in all policies' approach to local planning and policy.

According to the Plan, CHIRs could be built upon existing multi-organization collaborations aimed at improving local health care quality, such as consortia that are participating in the Robert Wood Johnson Foundation's Aligning Forces for Quality initiative, or serve as federally recognized Chartered Value Exchanges, or are testing the Pathways Community Hub model described earlier. Modeling CHIRs after these existing efforts was seen positively by some stakeholders and negatively by others, depending on whether they thought these existing consortia would receive new CHIR funding through the Plan or would be bypassed in favor of other yet-to-be-formed consortia. Several interviewees recommended aligning or combining CHIRs with other regional initiatives under way, such as the public behavioral health system's efforts.

The state plans to fund CHIRs from a variety of possible sources: a percentage of local ASCs' shared savings; nonprofit hospitals' community benefit programs; community development venture capital funds (which invest in companies in low-income areas); philanthropic funding; federal, state, and local funding; community trust funds; or fees collected by local public health departments in exchange for services.

New payment models. The Plan describes use of a variety of payment reforms that vary in the degree to which providers take on financial risk (e.g., monthly care management fees, pay-for-performance incentives, shared savings with no downside risk, partial capitation, or global capitation). During 2014, the state proposes finalizing the details of these payment models and incentives for patients, PCMHs, ASCs, and/or CHIRs. For example, the state is currently consulting with participating payers and ASCs to determine which populations/conditions to make the focus of a condition-specific global capitation approach. Care quality thresholds would need to be met in order to participate as an ASC in any of the proposed payment models.

Enhanced data systems. The state proposes using a Round 2 Model Test award to create or enhance a variety of data systems. These include the existing State of Michigan Data Hub (a collection of state-maintained health-related databases) and the existing MiPCT multi-payer cost and quality database. In addition, the state proposes a new dashboard system to prominently

display progress toward Plan goals; new mechanisms to rate and promote high-performing PCMHs, ASCs, and CHIRs to the public; and a new public directory that identifies providers' PCMH status and ASC affiliation.

15.3.2 Policy Levers

Existing and proposed policy levers for Plan implementation are listed in [Appendix Table 15A-1](#). The primary policy lever Michigan proposes to use for Plan implementation is organizing payers and providers around common delivery and payment models. A Round 2 Model Test award would provide a major catalyst to participation, by engaging Medicare to participate along with Medicaid and private payers. The funding from a Model Test award would allow the state to begin implementing its Plan in late 2014.

In addition, if the 2015 results of MiPCT are positive, the state plans to seek a Medicaid section 1115 waiver or state plan amendment to increase its Medicaid managed care capitation rates to permanently incorporate the PCMH demonstration payments. The state plans also to rely on voluntary, ongoing participation by private payers in MiPCT.

After the Model Test period, the state plans to promulgate ASC requirements for Medicaid managed care plans and participating private payers, either through state regulations or through future Medicaid managed care contracts, and may require all Medicaid managed care plan contracts to use new payment models developed as part of Plan implementation. The state hopes private payers will voluntarily choose to participate in the testing phase of the new payment models. The state also expects CMS to be able to recognize newly formed ASCs as ACOs through existing Medicare programs, due to their similarities. The state also plans to explore issuing regulations that would facilitate the formation of ASCs by preempting federal anti-trust laws and ensure Plan efforts comply with physician self-referral laws and anti-kickback laws.

The state may need to issue regulations to specify CHIR contributions from payers, health systems, and businesses, if the CHIR funding model is to be based on mandatory contributions. CHIRs are to be implemented by communities interested in adopting this model or strengthening existing CHIR-like efforts; several communities have already proposed partnerships with organizations interested in participating in CHIRs, and identified backbone entities.

The state is also to consider some workforce-related activities as part of Plan implementation, although these are not primary strategies the state is pursuing and are mentioned only briefly in the Plan. The state is contemplating creating a registry for community health workers, according to the Plan who are expected to have a role in care teams in primary care practices or CHIRs by working with particular patient populations. The state-maintained registry

could list individuals who have completed agreed-upon community health worker training. This would facilitate incorporation of this role in health care teams, because the role and required competencies would be well defined.

The state also notes that it will consider developing recommendations and guidelines for loan forgiveness and repayment programs for students who choose primary care specialties or health care professions with current or anticipated shortages. In addition, it proposes to work with the state legislature to reallocate some graduate medical education residency placements from hospitals to community-based entities.

Interviewees noted that the state legislature was also considering legislation unrelated to the Plan that would expand the scope of advanced practice registered nurses, thus increasing the supply of primary care providers.

Other than these efforts, the state has not identified specific legislative policy levers for implementing the five primary strategies in its Plan. External stakeholders perceived state legislation as being particularly difficult to enact in the current political climate; as one put it: “at every opportunity to implement something helpful, there is a legislature obstructing it.”

15.3.3 Intended Impact of the Plan

By the end of 2017, Michigan anticipates that a preponderance of the population *in the three pilot communities* will have an established relationship with a PCMH and be enrolled in a non-FFS payment model. By the end of 2019, Michigan expects that a preponderance of the population *in the state* will be enrolled in a non-FFS payment model and benefiting from population-level strategies of a local CHIR.

Michigan expects its Plan to help the state achieve a long list of specific health care performance goals that are part of its Health and Wellness Dashboard (Michigan Department of Community Health, 2011). It also plans to improve a number of indicators related to access to primary care, care quality, appropriate utilization of health care services, and patient experience. Over the long term, the state’s intent is to reduce overall morbidity (poor health) toward the national benchmarks described by the Robert Wood Johnson Foundation’s County Health Rankings:

- Percentage of adults reporting fair or poor health reduced from 14 percent to 10 percent
- Average number of physically unhealthy days in last 30 reduced from 3.5 to 2.6
- Average number of mentally unhealthy days in last 30 reduced from 3.7 to 2.3

15.3.4 Proposed Next Steps

Michigan will refine its Plan in 2014 and, if awarded a Round 2 Model Test award, plans to implement it in three pilot communities beginning in 2015, as noted, with statewide expansion in 2018. Michigan's 2014 planning activities are described as including refining the PCMH payment model to be used if MiPCT is extended, finalizing an ASC payment model, finalizing participation requirements for ASCs and CHIRs, and developing value-based payment models that private payers would be encouraged to voluntarily adopt. The state also plans to establish a performance and recognition committee with stakeholder representation to develop multi-payer performance measures, select the three pilot communities, and identify technical assistance needs. If the state does not secure a Round 2 Model Test award, some interviewees thought it would nevertheless continue with at least some aspects of the Plan—such as modifying its Medicaid managed care contracts to encourage ASC use and extending the MiPCT multi-payer PCMH demonstration.

The Michigan Department of Community Health's existing Policy and Planning Office is to be responsible for implementing the state's Plan, assisted by contractors and external stakeholders using two committees. A steering committee is to guide overall implementation, monitoring, and Plan refinement and finalize the new payment models proposed in the Plan by the end of 2014. A performance measurement and recognition committee is to transparently develop, implement, evaluate, and continually update a common set of performance measures to be used by providers to qualify for performance incentives under the Plan. These measures would focus on both health care delivery and overall population health, and would assess infrastructure development, clinical quality, cost containment, care coordination, and patient experience. This committee is also to review recognition criteria for PCMHs, ASCs, and CHIRs, with the goal of aligning recognition criteria and reducing administrative complexity.

15.4 Discussion

Stakeholders felt that the process used in Michigan to develop the Plan could be used in other states. When it came to selecting approaches to use in its Plan, Michigan chose to build on existing, well-regarded initiatives under way, due to the short timeframe available for Plan development and the benefits of using an incremental approach to health reform. It also chose to delay fully finalizing all details of its chosen payment models until after the Plan was submitted to CMS. One state staff leader thought more time would have allowed more intensive discussion with more stakeholders, and would have allowed an opportunity to identify potential Model Test regions and hold detailed discussions with potential Model Test participants to add detail to the models. These activities are now being conducted to prepare for the Model Test award application.

One state official said that health systems, providers, public health, local business, and payers had already stepped forward and expressed interest in serving as pilot communities—which they considered a positive sign. In addition, many stakeholders felt many components of the Plan would be feasible to implement. However, the ASC component of the Plan was described as presenting some difficulties, because the Michigan Association of Health Plans has formally opposed it. Nevertheless, according to a state official, four health plans have expressed interest in participating in regional tests of the ASC model, which is designed to align with Blue Cross Blue Shield of Michigan’s Organized System of Care (OSC) program; talks are continuing with this payer to create maximum alignment between ASCs and OSCs.

15.4.1 Critical Factors Shaping the Plan

Michigan developed the Plan based on analysis of existing provider and community capacity, according to stakeholders, and drew on existing health system reforms already under way. To do this, the state conducted an environmental scan—gathering information about existing initiatives under way in the state through its advisory committee, focus groups, interviews, and other data collection; it then incorporated several major initiatives into the Plan that are designed to move Michigan away from the FFS payment model and towards value-based payment and population health. Including a potential expansion of the MiPCT PCMH demonstration allows the state to build on the nearly 400 practices, which have already gained entry into that initiative and done extensive work transforming large and small practices into an interprofessional team-based model of care, as shown by the incorporation of 400 complex care managers.

Stakeholder involvement also shaped the Plan. For instance, initial concern about the requirements for an ASC led Michigan to propose the two levels of ASC capacity and corresponding payment models.

The Plan notes that in preparation for model testing, additional details must be finalized—such as ASC payment arrangements and the specific funding mechanisms that would support CHIRs. Some stakeholders expressed surprise that the state chose to delay finalizing payment models until Plan implementation is under way, and wished the state had been willing to discuss specific payment details earlier in the process of Plan development. And some felt that if large employers had been involved in Plan development at the outset, they would have been able to convince the state to modify its preferred approach of focusing on articulating its ideal care delivery system first, before discussing how to structure payments to achieve this goal.

15.4.2 Lessons Learned

Michigan’s experience developing its Plan yields several lessons, according to stakeholders:

- **Incremental reforms that build on existing initiatives were attractive to some stakeholders**—since they take less time to develop, build support for, and implement, and take into account and capitalize on “facts on the ground.” However, the downside to this approach, as viewed by others, is that these strategies are not “innovative,” due to their familiarity.
- **Focusing on delivery system reform left less time for payment reform details to be worked out.** Michigan chose to focus first on identifying and building consensus around delivery system reform, before turning to payment reform. The state thought discussing payment reform too early could lead to a crowding out of discussions about what their ideal delivery system should look like. Some stakeholders disagreed with this approach, since they thought the way payment is designed can influence what delivery systems look like, and the one could not be discussed without the other. The state’s sequential approach to discussing these topics also left less time than some thought would have been ideal to flesh out payment model details during the Model Design grant period, though Michigan has made strides in defining payment details in collaboration with stakeholder groups in the months following its Plan submission.
- **Purchasers are an important stakeholder group to include from the beginning, especially in a state like Michigan with large self-insured employers.** Failing to include these stakeholders from the beginning of Plan development may have affected the Plan design, and may reduce buy-in and Plan implementation components that are reliant on voluntary actions from these actors, according to some stakeholders—though the state made an effort to consult with these parties midway through their Plan development process, and continues to consult with them. Uncertainty remains as to how many payers will seek out contracts with plans that involve ASCs, and whether private plans will choose to contract with ASCs.

15.4.3 Potential for Implementation

Many of the stakeholders felt the Plan would be feasible to implement with adequate funding. In addition, the fact that organizations in several communities had already stepped forward and expressed interest in participating in CHIRs was taken as suggesting this component of the Plan would be feasible to implement. That said, interviewees were divided on whether CHIRs should be implemented only in communities where they are likely to flourish or in a mix of communities with varying degrees of readiness for that model.

Quite a few interviewees recognized challenges to Plan implementation. The ASC component of the Plan had more support from entities that had experience implementing the ACO model than from those that did not. One large health system that had already adopted the ACO model saw ASCs as a way of creating an entity that could simplify their relationships with health plans—by developing uniform standards for quality metrics, payment systems, and PCMH recognition, as well as providing support to practices. But managed care plans felt that

ASCs represented an added layer of bureaucracy that would impede their existing efforts and relationships with providers. If existing managed care plans are unwilling to participate fully in the ASCs and implement new payment systems, according to interviewees, this could create major implementation problems for the state. And if the health plans hold to their current provider contracts, payment arrangements, and quality oversight, it could make it hard for the ASCs to play the role envisioned in the Plan or could limit the number of entities that sign up to serve as ASCs. Even so, a state staff leader thought it encouraging that four health plans have come forward in support of testing the ASC model at the local level.

Another area of uncertainty expressed about implementation relates to the participation of large self-insured employer plans, which were absent from the early stages of the stakeholder process and may feel the Plan does not reflect their goals. Some suggested that these health plans could support the idea of ACOs but seek separate arrangements that differ from the ASCs created by the Plan. Similarly, they thought these health plans may decide not to join MiPCT if the state expands it to more payers, or may decide not to contribute funds to CHIRs. As one interviewee pointed out, payers are already developing and adopting their own payment reform models without the state's help.

A further implementation challenge that was noted was lack of clarity about what the state would do, if anything, to promote the PCMH model if the results of the MiPCT evaluation due out in 2015 are not favorable enough to convince the state to extend and expand that initiative.

Concerns were also expressed about the feasibility of implementing the Plan in the face of other policy changes that would be taking place in the state. In addition to the ongoing demonstrations related to MiPCT and integrated care for dual Medicaid-Medicare beneficiaries, interviewees felt that the Healthy Michigan Medicaid expansion and the continued development of the health insurance marketplace might strain the state's capacity for implementing the policy changes required for Plan implementation. With so many other health policy and reform activities going on, it was felt that politics may result in compromises that relegate Plan implementation to a lower priority than other initiatives.

Finally, as with any major initiative involving health IT, some expressed concerns about the ability to get data system infrastructure enhancements envisioned in the Plan up and running quickly. One person saw the IT piece as a prerequisite for much of the remainder of the Plan: "you have to be realistic ... before you can implement some of these things, you have to make sure your IT systems are in place in order to do it. You can't just say, okay, we're going to do this, we're going to get a bunch of providers together and they're going to do this. They have to have data. They have to have IT systems. They have to have it in place."

15.4.4 Applicability to Other States

Stakeholders felt that the process used in Michigan to develop the Plan could be used in other states and strongly advised other states that apply for Model Design awards to start planning efforts early and to not necessarily wait for funding from CMS to be awarded. Interviewees also suggested that the early stages of the process include open discussions during which stakeholders could decide who else needed to be included in order to have a broad input. In addition, several stakeholders suggested that states should not work in a vacuum and should look to the experiences of other states for ideas. Interviewees also suggested states consider a Plan that could achieve small successes, as opposed to looking for broad reforms that might be “pie in the sky.”

15.4.5 Limitations of This Evaluation

The major limitation of this study is that we were unable to attend committee meetings in person, which may have limited our understanding of the dynamics in the state. Moreover, interviews took place between October and December of 2013, before the Plan was finalized. Because of this, our interviews only captured issues that were salient at a particular point in time in the state’s Plan development process, and may not reflect stakeholder opinions of the final Plan. We also concentrated our interviews among the state officials and organizations that were heavily involved in Plan development and did not interview some major players in Michigan that were not involved in its development. This may have precluded better understanding of how the process was perceived by these outside stakeholders and their organizations, and limited our ability to draw a comprehensive assessment about the feasibility of Plan implementation.

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Appendix Table 15A-1. Models and strategies proposed in Michigan Health Care Innovation Plan

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|---|--|--|---|--|
| <p>Patient-centered medical homes Extension of the MiPCT, a multi-payer PCMH initiative, and currently part of CMS’ Multi-payer Advanced Primary Care Practice Demonstration</p> | <p>MiPCT</p> | <p>Enrollees of plans participating in MiPCT: Blue Cross Blue Shield of Michigan, Blue Care Network (an HMO), Priority Health, Medicaid, and traditional fee-for-service Medicare</p> | <p>Potential voluntary actions *Private payers voluntarily continue participating in the MiPCT Potential state executive branch action *Extend the MiPCT Demonstration beyond 2015 *Seek Medicaid section 1115 waiver or state plan amendment from CMS to add MiPCT payments to the rates paid to managed care plans Potential federal action CMS agrees to continue Medicare’s participation in MiPCT</p> | <p>Private payers participating in MiPCT: Blue Cross Blue Shield of Michigan, Blue Care Network (an HMO), Priority Health Michigan Department of Community Health (Medicaid) CMS (Medicare) Primary care practices</p> |
| <p>Accountable care organizations ASCs</p> | <p>Blue Cross Blue Shield of Michigan’s “Organized Systems of Care” ACO program Medicare’s various ACO programs (e.g., Shared Savings, Pioneer ACO, Physician Group Practice initiative)</p> | <p>Most Medicaid managed care beneficiaries (but not special populations addressed through other programs, such as dually eligible beneficiaries) Medicare beneficiaries Enrollees of voluntarily participating private payers</p> | <p>Potential state regulatory action *Issue regulations describing requirements entities must meet to be ASCs Proposed state executive branch action Modify Medicaid managed care contracts to require plans to be (or contract with) ASCs Potential state facilitation of system change *Private payers voluntarily contract with ASCs Proposed federal action CMS approves ASC applications to participate in Medicare ACO programs (e.g., Shared Savings, Pioneer ACO model)</p> | <p>Michigan Department of Community Health Voluntarily participating private payers CMS (Medicare) Primary care providers, specialists, hospitals</p> |

(continued)

Appendix Table 15A-1. Models and strategies proposed in Michigan Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|---|---|--|--|--|
| Infrastructure for population health CHIRs | Pathways Community Hub model being tested in three communities with a CMS Health Care Innovations Award Federal Chartered Value Exchanges Grantees of the Robert Wood Johnson Foundation’s Aligning Forces for Quality initiative Washtenaw Health Initiative Greater Detroit Area Health Council | All individuals living in a given “Prosperity Region” (preexisting geographic areas eligible for state-funded economic development grants) | Potential state regulatory action *Specifying what types of entities (e.g., payers, health systems, businesses), if any, will be required to support CHIRs, what amount they will be required to contribute, how funds will be collected, etc. Potential state executive branch action Modify Medicaid managed care contracts to require ASCs to contribute to CHIRs Proposed state facilitation of system change Cross-sector organizations in pilot communities will choose to participate in CHIR efforts | Michigan Department of Community Health A variety of types of community organizations |
| New payment models For PCMHs, ASCs, and CHIRs | MiPCT project; ACO contracts | Medicaid beneficiaries Enrollees of voluntarily participating private payers | Potential state executive branch action State requires the use of new payment models for ASCs in its Medicaid managed care contracts Potential state facilitation of system change *Private payers adhere to ASC specifications in their contracts with providers | Michigan Department of Community Health Voluntarily participating private payers |

(continued)

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Appendix Table 15A-1. Models and strategies proposed in Michigan Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|------------------------|---|-----------------------|---|---|
| Enhanced data systems | Health Information Exchange investments Michigan Department of Community Health Data Hub (a collection of state-maintained health-related databases) Michigan Data Collaborative, a multi-payer claims database for payers and practices participating in MiPCT | N/A | Proposed state executive branch action Enhancements of existing data systems Proposed federal action *Round 2 Model Test award | Michigan Department of Community Health University of Michigan |

¹Policy levers include Medicaid waivers; federal grants (including Round 2 SIM award); state laws; state regulations; state investments (e.g., in public health programming); foundation grants; employer-led coalitions to drive change among providers, purchasers, or plans; state government-led coalitions, task forces, or commissions to drive voluntary change among providers, purchasers, or plans; state purchasing contracts; and state-level (Governor-initiated) executive policy directives.

Abbreviations: ACO = accountable care organization, ASC = accountable system of care (modeled after ACOs), CHIR = Community Health Innovation Region, CMS = Centers for Medicare & Medicaid Services, HMO = health maintenance organization, MiPCT = Michigan Primary Care Transformation, N/A = not applicable, PCMH = patient-centered medical home, SIM= State Innovations Model.

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16. New Hampshire

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New Hampshire established a new planning structure to develop its Health Care Innovation Plan (the Plan), with open membership on both work groups and the stakeholder advisory committee, participation of many long-term services and supports (LTSS) consumer advocates and providers, and consensus-based decision-making, reflecting the New England town meeting tradition. The process, in which the Governor’s Office also participated, was guided by the New Hampshire Department of Health and Human Services (NH DHHS) and facilitated by its contractor, Deloitte Consulting LLP. Planning took place during a period that also involved the state’s transition to mandatory Medicaid managed care for most populations.

The Plan focuses on improving care for LTSS users and those at risk of using LTSS, who account for 64 percent of the Medicaid budget. The state is implementing separate initiatives to transform care for the general population, for example, the Medicaid Care Management Program and the Balancing Incentives Program (BIP) initiatives. Key strategies in the Plan include expanding access to LTSS and preventive services, person-centered planning and care management, consumer-directed services with individual budgets, and use of financial incentives to encourage healthy behaviors and preventive care. Most features are designed for implementation by Medicaid, but the state is working to engage other payers on a voluntary basis. Other levers proposed include a Medicaid section 1115 waiver and possibly other Medicaid authorities, and Medicaid managed care contracts.

16.1 Context for Health Care Innovation

NH DHHS and its contractor, Deloitte Consulting LLP, convened stakeholders to discuss strategies that would help reduce the cost of long-term care in the context of: (1) the Medicaid Care Management (capitated managed care) model for administering the New Hampshire Medicaid program, which began in December 2013; (2) the state’s BIP; and (3) a current LTSS system that consists of a number of “siloes” subsystems with limited consistency of services, care management, and delivery systems.

In June 2011, New Hampshire signed into law An Act Relative to Medicaid Managed Care (New Hampshire Senate Bill 147). Under the law, the vast majority of Medicaid enrollees will eventually be transitioned from a traditional fee-for-service (FFS) into a capitated managed care model. Currently, three Medicaid managed care organizations (MCOs) operate in New Hampshire: New Hampshire Healthy Families, Meridian Health Plan, and Well Sense Health Plan. Each MCO is required to develop an integrated care management program for enrollees

with multiple physical or behavioral health comorbidities. Each MCO is also required to develop and implement a payment reform strategy. Phase 1 of Medicaid Care Management (capitated managed care) in New Hampshire began on December 1, 2013, and covers most Medicaid enrollees, including mental health service coverage. Medicaid Section 1915(c) Home and Community-Based Services waiver programs, through which LTSS are provided to qualifying individuals, will become part of the Medicaid managed care model in Phase 2, set to begin December 2014. New Hampshire is designing a model for coordination of these services in Phase 2; the state will develop a more detailed implementation plan for the strategies and concepts that are part of the Plan (New Hampshire DHHS, December 2013).

New Hampshire has broad bipartisan support for managed care in state government; however, LTSS stakeholders do not uniformly support the transition to managed care. The developmentally disabled community is opposed to managed care and has initiated a lawsuit against the state to stop inclusion of people with developmental disabilities in managed care. The primary opposition is around individual budgets and who will manage them—the MCOs or the agencies that provide services to people with developmental disabilities. Currently, these agencies manage the budgets and retain any savings, and are concerned that this will change with the move to managed care.

In September 2012, New Hampshire began work on its BIP project. The purpose of this program is to (1) rebalance Medicaid spending between institutional and noninstitutional long-term care, (2) develop and implement structural changes to enhance systems performance, and (3) improve access to and offerings of home and community-based LTSS to allow those needing long-term care through Medicaid to be served in the home and community to the extent possible (New Hampshire DHHS, September 2012a). Additionally, New Hampshire seeks through this program to create a system with “no wrong door” entry to LTSS. Currently, about 1,000 individuals in New Hampshire are already managing their own consumer-directed LTSS budgets. The Plan would increase the number of individuals directing their own budgets across all waiver populations.

New Hampshire’s LTSS system, in general, is fragmented and siloed and does not consistently promote coordination of services across the different delivery systems. In addition, New Hampshire’s current approach to LTSS has varied across different populations and waiver programs. The counties absorb some of the Medicaid LTSS costs, and each county operates at least one nursing facility. New Hampshire has 10 mental health centers and each is a private nonprofit entity that maintains a contract with the state to serve Medicaid populations. Further, mental health centers, which serve everyone regardless of their ability to pay for care, currently operate on an FFS model.

New Hampshire has a population of 1,320,718, of which 29 percent are enrolled in Medicaid or Medicare. New Hampshire has four private insurers that serve 12,000 or more

people each: Anthem/Matthew Thornton (38 percent market share), which participated in the Model Design process; Harvard Pilgrim Health Care (11 percent); CIGNA (6 percent); and MVP Health Insurance Company of NH (1 percent). The remaining private insurers cover 10,565 New Hampshire citizens (<1 percent). New Hampshire's uninsured population numbers 44,704 (3 percent) (New Hampshire DHHS, December 2013). The state projects that 62,237 citizens (5 percent) would be covered through Medicaid expansion. On March 27, 2014, the Governor signed the state's Medicaid expansion into law (Associated Press, 2014). As noted, New Hampshire's SIM Initiative focus is on individuals in need of, or at risk for, LTSS, and is driven by the fact that this population accounts for almost two-thirds of the state's \$1 billion overall Medicaid budget.

New Hampshire's most recent gubernatorial election in November 2012 resulted in a new administration. New Hampshire's Model Design application was written during the administration of the previous Governor John Lynch. The majority of the development of the state's proposed Plan, however, took place under the administration of his successor, Maggie Hassan. Despite the change in administration, the Governor's office remained involved in the planning process.

New Hampshire developed the Plan using an open and inclusive process, which according to many interviewees reflects a tradition the state has of town meetings, where everyone is heard and able to speak. This tradition is also reflected by the size of the state's legislature, the General Court of New Hampshire. With 424 members (400 State Representatives, 24 State Senators), it is the fourth-largest English-speaking legislative body in the world, behind only the Parliament of the United Kingdom, the Parliament of India, and the United States Congress (State of New Hampshire, 2012).

16.2 Planning Infrastructure and Process

Development of the Plan was led by NH DHHS, which hired the contractor Deloitte Consulting LLP to facilitate the planning process. The planning process was explicitly designed to be open, allowing participation by anyone at any time, and stakeholders overwhelmingly agreed that the process was inclusive. A few stakeholders said that the open stakeholder engagement process may have allowed one group—the developmental disabilities community—to dominate the discussion through their ability to bring the largest number of representatives to meetings.

Governance and management. NH DHHS served as the lead agency for the Plan development process, in which the Governor's Office also participated. An NH DHHS official chaired each of the work groups; however, work group meetings were facilitated by consultants from Deloitte Consulting LLP, who also recorded and synthesized meeting notes and prepared the written Plan.

NH DHHS and Deloitte Consulting LLP engaged stakeholders in the proposal stages of the SIM Initiative, holding an introductory meeting on September 12, 2012 to share information about the Initiative opportunity and introduce NH DHHS' goal: "To achieve overall system transformation through payment reform for [the] costliest and most at risk consumers" (New Hampshire DHHS, September 2012b). NH DHHS also hired an actuary, Milliman, to prepare analyses of projected expenditures for the state's users of LTSS. These actuarial analyses are included as appendices to the Plan.

Stakeholder engagement. Before receiving the SIM award, NH DHHS gathered stakeholders for a "values and visioning meeting," which was facilitated by Deloitte Consulting LLP on November 7, 2012. At this meeting, the consultant laid out the organizational structure and timeline for the SIM Initiative process, and attendees developed the core values that would drive the process (New Hampshire DHHS, November 2013).

All New Hampshire residents were invited to participate in periodic stakeholder meetings. This Stakeholder Advisory Committee was established to validate the Model Design developed by separately convened work groups. The committee did not have a set membership, but instead was open to any and all interested stakeholders. The committee met roughly monthly throughout the Plan development process. At these meetings, NH DHHS presented portions of the Plan that had been developed through work group meetings, and Deloitte Consulting LLP facilitated discussions that sought feedback and input from everyone present.

Stakeholder Advisory Committee meetings were attended by a range of stakeholders, including payers, LTSS providers, consumer advocates, and many work group members. Some important stakeholders were missing from the stakeholder engagement process—notably, counties, public and private nursing facilities, and Veterans Health Administration medical centers, which were invited to participate in the plan development process but were not actively engaged. Several stakeholders expressed concern about the lack of county engagement, because counties finance the state's share of Medicaid LTSS for older adults and the physically disabled, as well as operate public nursing facilities. Some stakeholders felt that the elderly, overall, were underrepresented at these meetings, in contrast to the developmentally disabled constituency, which was heavily represented.

SIM work groups. New Hampshire began the planning process by establishing six work groups to develop key areas of the Plan: (1) delivery system redesign, (2) payment reform design, (3) existing initiatives, (4) regulatory and legal barriers, (5) health information technology (health IT)/IT needs, and (6) other barriers and challenges (New Hampshire DHHS, December 2012). Based on stakeholder feedback, two additional work groups were added: (7) quality, and (8) education/outreach (New Hampshire DHHS, May 2013). Each work group included state officials along with payers, providers, and consumer advocates for the elderly and disabled. Each work group was chaired by a state official but facilitated by Deloitte Consulting

LLP. The work groups met monthly throughout the planning period. Their ideas were synthesized by Deloitte Consulting LLP and presented by NH DHHS to the stakeholder advisory committee, with Deloitte Consulting LLP facilitating feedback in an iterative process.

Consumer engagement. To gather feedback and input directly from the consumers who would be affected by the models presented in the Plan—Medicaid beneficiaries using LTSS—NH DHHS, through Louis Karno & Company Communications, conducted consumer focus groups and an online survey. In total, 92 consumers participated in these focus groups—representing people with physical disabilities or behavioral health issues, families of people with developmental disabilities or behavioral health issues, and professionals who work with LTSS users and their families. The survey was designed with input from the education and outreach work group. More than 500 individuals completed the survey, half of whom were family members, caregivers, or guardians of those who use LTSS. Six percent of respondents identified themselves as individuals who currently use New Hampshire’s Medicaid long-term care services. Other respondents identified themselves either as service providers or as neither users nor providers (Louis Karno & Company, December 2013).

NH DHHS maintains a SIM Initiative Web site (<http://www.dhhs.state.nh.us/ocom/sim.htm>) where documents are publicly posted. Materials posted on the Web site include New Hampshire’s original proposal, presentations prepared by Deloitte Consulting LLP for stakeholder meetings, materials from some of the work group meetings, drafts of the final Plan, and consumer feedback on the Plan gathered through surveys and focus groups. The Web site does not provide an immediate method for the public to give feedback about these materials.

16.3 The New Hampshire Plan

New Hampshire would build on several initiatives that encourage a rebalancing and realignment of the state’s LTSS system as the centerpiece of the Plan. New Hampshire seeks to develop a system that places an emphasis on consumer direction, with “no wrong door” entry into the LTSS system. New Hampshire plans to implement its model across the entire LTSS population and integrate it as Step 2 of the state’s transition of both primary care and long-term care services to Medicaid managed care. New Hampshire’s proposed policy levers include adopting Medicaid state plan amendments (SPAs) and waivers as needed.

The Plan includes additional strategies to create a “Global Triple Aim Incentive Pool” of funds that would allocate any savings gained through the model across participating payers and providers serving individuals receiving LTSS. These savings would be reinvested in workforce training, health IT, and other capacity building efforts. The state would also align public health and prevention goals with the strategies in the model.

16.3.1 Models and Strategies

The Plan proposes the “Prevention Focused and Person-Centered and Driven LTSS Initiative,” which envisions a system that redesigns how LTSS consumers access comprehensive services and how these services are coordinated, and gives individuals more control over the services they receive (New Hampshire DHHS, December 2013). *Appendix Table 16A-1* provides a summary description of the innovations, initiatives on which they are built, populations they address, proposed policy levers, and supporting implementation entities. The LTSS Initiative has two parts: (1) access to services and improved care and service coordination for those receiving LTSS, and (2) promotion of individuals’ ability to access and direct needed LTSS, with a goal of significantly increasing the number of individuals directing their own LTSS budgets. This is a major design element of the Plan—a feature New Hampshire plans to standardize across all Medicaid waiver populations.

Expanded access and equalization of LTSS. New Hampshire plans to expand the criteria for LTSS eligibility to reach a larger population, which the BIP team would draft. This expansion would include individuals at risk for needing a higher level of service in the future if LTSS are not provided. Additionally, New Hampshire would expand availability of the LTSS Eligibility Assessment to individuals nearing a transitional point (e.g., youths about to leave the school system who will soon be eligible for LTSS). The state also plans to improve access to needed services by providing individuals access to the full range of LTSS, regardless of which LTSS waiver program or LTSS state plan the individual is determined eligible for.

Person-centered care planning, coordination, and Health Homes. Individuals eligible for LTSS services would receive assistance to create a Life Plan. This is an important part of New Hampshire’s model to ensure there is a “no wrong door” entry into the LTSS system. The Life Plan lists services and supports currently provided by all payer sources and needed services and supports not currently covered by a payer. This plan would be created with the staff of the various agencies to ensure that, no matter through which agency the individual entered the system, the services received would be coordinated.

In addition to Life Plan development, all recipients of LTSS services would select an individual to assume a team coordinator function, where applicable. The team coordinator would coordinate with providers, assist in managing the LTSS budget, support changes to the LTSS budget, assist the individual with LTSS provider selection, assist in accessing needed services, and periodically update the Life Plan with the individual. Team coordinators would have to complete a training program and recertification programs on a regular basis. Recipients of LTSS services would be able to choose an individual employed by an MCO, an LTSS provider, or a family member to act as the team coordinator.

Finally, the state intends to deploy a statewide health home model during Phase 2 of its Medicaid managed care rollout. New Hampshire would also work with commercial insurers and other payers to adopt the Medicaid Health Home model for their enrollees. New Hampshire plans to expand on the federal definition of a health home to include individuals who have both LTSS needs and a behavioral or physical health comorbidity.

Consumer-directed care with individual budgets and reimbursement accounts. The team coordinator—working with the individual, providers, and where appropriate, the individual’s MCO—would create a proposed annual individual LTSS budget based on the needs derived from the Life Plan. The MCO would review and recommend the proposed budget to NH DHHS, which would make a final budget decision and notify the individual and the MCO. New Hampshire has identified a set of four principles to be considered with regard to pricing LTSS: (1) need for access within the delivery system; (2) standardized budget methodology across all populations; (3) circumstances of the individual, allowing for individualization; and (4) cost of services and supports. Individuals across all waiver populations would manage their approved budgets through an LTSS reimbursement account, administered by either the MCOs or the agency to which the MCO delegates authority, building on a pilot program already in place in the state.

Supporting strategies. New Hampshire has begun to identify strategies to align public health and prevention goals with the LTSS Initiative, such as incorporating incentives and rewards for participation in public health programs into the design of LTSS reimbursement accounts. The state also proposes to align substance misuse services with an individual’s Life Plan (New Hampshire DHHS, December 2013). New Hampshire has identified several priority areas for health IT to be addressed through the SIM Initiative and has also recommended amending legislation to identify LTSS providers as eligible participants in the health information exchange (HIE).

Another strategy that would supplement the LTSS Initiative is the Global Triple Aim Incentive Pool described earlier. Each year, New Hampshire would project spending for all medical, behavioral, and LTSS costs for individuals receiving LTSS. Based on this amount, the state would establish a savings target. If the target is met, savings would be distributed to the payers, providers, and a reinvestment fund. The provider payouts would be determined based on quality performance measures and results. Unused funds would go to improvement projects related to underperforming measures. The reinvestment fund, as noted, would finance initiatives related to training, workforce development, and health IT.

Other models and strategies considered but rejected from the Plan. New Hampshire did consider other health care delivery and payment models, such as the patient-centered medical home (PCMH) and accountable care models. These will not be implemented through the Plan, although New Hampshire does intend to implement PCMHs through the Medicaid MCOs.

16.3.2 Policy Levers

Existing and proposed policy levers for Plan implementation are listed in *Appendix Table 16A-1*. The Plan includes a chart listing components of the model and indicates each potential policy lever—rule change, statute change, MCO contract change, Medicaid SPA, or Medicaid waiver authority.

Stakeholders identified two key Medicaid levers: a Medicaid section 1115 waiver, and the Medicaid managed care contracts. The section 1115 waiver would be used both to expand Medicaid managed care by adding LTSS and mandating participation of other populations and to authorize some elements of the Plan (New Hampshire Commission on Medicaid Care Management, August 2013). As a state official explained: “CMS has said ‘tell us what you want to do, and we’ll work with you to figure out which waiver is the right one.’... We’re going down the path of some SPA [state plan amendment] for basic services and a combined 1115 [waiver] for everything else.”

The Plan also notes that NH DHHS will work with legislators on obtaining any necessary state authorizations. Concretely, the Plan states that New Hampshire will seek a legislative change authorizing LTSS providers’ access to the state HIE system. After obtaining authorization for Medicaid changes, state officials plan to use their Medicaid managed care contracts to delegate implementation of some strategies to the MCOs.

New Hampshire proposes applying for the Medicare-Medicaid Financial Alignment Initiative to enable the state to integrate Medicare and Medicaid for dually eligible beneficiaries, who constitute a majority of the LTSS population. It may be too late to apply for that initiative, but the state would be able to use its Medicaid section 1115 waiver to mandate enrollment of dually eligible beneficiaries in Medicaid managed care. The Plan also envisions voluntary action by payers other than Medicaid and Medicaid MCOs. For example, state officials have talked with commercial insurers about providing preventive services to individuals at risk of needing LTSS, and with the Veterans Health Administration about collaborating on some of the Plan’s LTSS strategies.

Federal funding is another key lever in the Plan. A state official said a Round 2 Model Test award would be needed to fund training components in the model and to develop health IT infrastructure for managing individual budgets and incorporating LTSS providers into the HIE. The state is already leveraging its BIP funding to begin work on its training supports and other elements.

16.3.3 Intended Impact of the Plan

New Hampshire has planned and begun to implement strategies to reach much of the state’s population, including transitioning most Medicaid beneficiaries to capitated managed care

and implementing multi-payer payment reform, delivery system reforms, and a multi-payer public health wellness strategy. However, those strategies are not part of the Plan. Rather, the Plan focuses on improving care management for individuals who use LTSS or are at risk of needing LTSS, regardless of the payer. The Plan also seeks to expand use of consumer-directed budgets for home and community-based services, currently used primarily by individuals with developmental disabilities. The state's analysis shows that Medicaid LTSS users also have high acute care costs. Although LTSS users are a fraction of the state population, the cost of their care affects most of the population, either directly as LTSS users or family caregivers, or indirectly through the high cost of health care and LTSS. New Hampshire sought to expand the Plan's impact by engaging other payers serving segments of the LTSS population—including Medicare, commercial insurers, the Veterans Health Administration, and schools. It was successful in engaging Anthem, the state's largest commercial insurer, and the three Medicaid managed care plans to participate in the stakeholder process.

16.3.4 Proposed Next Steps

The model strategies and supporting structures the Plan proposes to use to reform the way LTSS are delivered in the state would be phased in beginning in late 2014. The first strategies to be implemented would be those associated with New Hampshire's Medicaid managed care expansion, including expanded LTSS eligibility criteria and consumer directed LTSS reimbursement accounts. Additional strategies would be implemented in 2015.

New Hampshire plans to pursue both a Round 2 Model Test award and a Medicaid section 1115 waiver and to seek various state approvals in 2014. NH DHHS plans to pursue some elements of the model even without a Round 2 Model Test award.

16.4 Discussion

According to stakeholders, the most influential factors shaping New Hampshire's Plan were the current status of New Hampshire's LTSS system, its fragmented nature, and recognition by the state and by stakeholders that it needed to be changed. Another influential factor was said to be the developmental disability community, both providers and consumers, and the fear in that community that individual budgets would be controlled by MCOs rather than provider agencies.

16.4.1 Critical Factors Shaping the Plan

Many stakeholders noted the current complexity and fragmentation of New Hampshire's LTSS system. The Plan notes that the state chose to focus on the LTSS system and population for three reasons: (1) the population has complex needs served by multiple service delivery systems that have struggled to coordinate care, (2) multiple payers access these delivery systems and have little commonality in their approaches to care management and consumer engagement, and (3) there is currently no mechanism to look across the delivery systems and across the payers

to measure the cost-effectiveness of services or measure performance. Stakeholders—especially but not only state officials—pointed out that given the cost of LTSS, the focus on this system and this population was critical. One state stakeholder commented: “Here is...20 to 30 percent of the overall Medicaid population, but it is 80 percent of our budget. So if we don’t start addressing that and flipping that, this is ultimately not sustainable for the entire Medicaid population, let alone the impact on private insurance and other entities.”

Almost all stakeholders agreed that the developmental disability community, both providers and consumers, was the most influential in development of the Plan. Many stakeholders commented that the developmental disability community felt threatened by the move to Medicaid managed care and had, as noted, initiated a lawsuit against the state to stop the inclusion of consumers with developmental disabilities in Phase 2 of the Medicaid managed care rollout transition. Additionally, one stakeholder pointed out that the threat of legislation being introduced would allow the developmental disability community to delay its involvement in managed care long-term services for another 2 years. The developmental disability community’s opposition toward managed care has led it to be very vocal throughout the planning process. Its influence was felt particularly in the aspects of the Plan related to consumer-directed care, LTSS budgets, and the team coordinator function. One stakeholder noted: “Our DD [developmental disability] community and our family partners who have children with chronic health care needs have been amongst the most influential in that they have greater experience with consumer-directed care.”

Stakeholders were torn on whether the developmental disability community’s influence was a positive one. One stakeholder commented: “The process itself was very dominated by the developmental disabilities system, which is a concern....I think the end game, the end plan is tainted toward that system and how it has evolved.” Stakeholders were also concerned that the developmental disability community’s concerns ran the risk of crowding out others, but ultimately felt that most of the others were heard. A one stakeholder put it: “There was a time when the elderly delivery system and the community mental health delivery system had to compete for airtime with the DD [developmental disability] community. But at the end of the day, I think they felt that they got heard. But that was a dynamic; the DD [developmental disability] focus was really active.”

16.4.2 Lessons Learned

Several lessons can be gleaned from New Hampshire’s planning process, according to stakeholders.

- **The open process without ground rules for participation allowed one stakeholder group to have more influence than other groups.** No one objected to the open process, which allowed any citizen to participate in the work groups and general stakeholder meetings, and several said it enriched everyone’s understanding.

However, stakeholders observed that the developmental disability community had more influence because of their large numbers, and other consumer stakeholders wished their groups had been better represented at work group meetings.

- **Building consensus was valuable, but time-consuming.** One of the state’s contractors said: “My biggest lesson learned is that consensus is a good thing, and it takes a long time to get there.” A few stakeholders said that fluctuating attendance made it necessary to spend the first part of each meeting reviewing previous discussion. Others found that helpful, however; and one mentioned positive changes to strategies based on comments during such review.
- **The condensed timeline was difficult for a participatory process.** Stakeholders and state officials found the short timeline challenging rather than helpful. “The accelerated process for planning creates risk,” said a disability service provider. “[T]he planning process is truly a consensus-building process; if you accelerate it, there’s a greater risk that you don’t take time to build that consensus.”

16.4.3 Potential for Implementation

New Hampshire’s highly participatory and consensus-based Model Design process helped build solid support for the person-centered strategies in the Plan. State officials were enthusiastic about the potential for implementation. But LTSS consumers and providers, although generally optimistic, harbored some reservations because of concerns about the role of MCOs.

A state official said New Hampshire has the resources to implement the Plan through managed care contracts and BIP funds, but that a Model Test award would help implement the training components and health IT infrastructure. Another stakeholder said: “It is a very complicated plan that’s being laid out. I think it will take a lot of time. I think if the Department is committed to it, I think everything in it is doable. So I am carefully optimistic, I guess.” We noted that the state is undertaking a number of significant changes in a relatively short period, including adding LTSS and possibly dually eligible beneficiaries to Medicaid managed care, and implementing medical homes and Health Homes for Medicaid beneficiaries. Because of lean NH DHHS staffing, state officials expect to delegate significant portions of the Plan’s implementation to Medicaid MCOs. One payer expressed concern about whether new Medicaid MCOs could implement consumer-directed individual budgets at the same time they would be adding LTSS.

Some stakeholders’ enthusiasm may have been dampened by concern about Medicaid managed care. Stakeholders said that when MCOs began attending meetings, many participants became alarmed about the MCOs’ role in implementation. They said the MCOs primarily listened during planning sessions, and facilitators and state officials did not have answers about the role of MCOs. Developmental disability advocates and providers were especially concerned

about ceding control of assessments, service plans, and individual budgets to the MCOs. Other LTSS populations are supportive of managed care as a means of coordinating care and rebalancing LTSS, according to one aging advocate, who added that “how [the Plan] interacts with the Medicaid managed care rollout will be critical.”

Several stakeholders also mentioned uncertainty about whether New Hampshire’s 10 counties would support the proposed changes. Although the counties finance the state share (50 percent) of Medicaid LTSS for older adults and adults with disabilities, they did not participate in the planning process, despite the state’s efforts to engage them. Although counties are concerned about the high cost of LTSS, they also operate nursing facilities, and no one knows how these facilities would react to the proposed changes. Private nursing facilities did not participate either, and it was not clear whether they might consider the proposed strategies a threat.

Despite the barriers, stakeholders thought implementation of the proposed strategies was feasible. New Hampshire has experience with consumer-directed services, although it needs to adapt current practices to a managed care environment, add new features, and expand to other populations and provider types. The state has a lever to effect change through managed care contracts and existing resources from the BIP, and has already engaged BIP staff at the University of New Hampshire to help develop various components of the Plan that overlap with BIP objectives. Implementation may necessitate a longer phase-in period to avoid overloading the NH DHHS, MCOs, and providers with concurrent new initiatives, according to stakeholders, and to allow consumers and providers to adapt to a managed care environment.

16.4.4 Applicability to Other States

We did not hear identification of any Plan features that were unique to implementation in New Hampshire. Some of the key strategies in the Plan, such as consumer direction with individual budgets and person-centered planning, have been implemented in various forms elsewhere, but the degree of consumer direction envisioned in New Hampshire’s Plan may be of interest to other states, according to stakeholders.

16.4.5 Limitations of This Evaluation

This case study was developed on the basis of our review of publicly available documents and our interviews with stakeholders in New Hampshire. We were not able to speak with all the stakeholders we identified, however. Notably, the Governor’s Office declined our request for an interview, citing the need to prepare for a special legislative session. Additionally, we were unable to speak with any behavioral health consumer. Lastly, we spoke with stakeholders before the New Hampshire legislature voted on Medicaid expansion (Associated Press, March 2014) and before the state submitted its final Plan. Thus, stakeholder comments reported may not accurately reflect opinion of the final Plan.

16.5 References

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Appendix Table 16A-1. Models and strategies proposed in New Hampshire Health Care Innovation Plan

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ | Entities that will be involved in implementation |
|---|--|-------------------------|---|---|
| Expanded access and equalization of LTSS | | General LTSS population | <p>Proposed state executive branch action</p> <p>Rule change, SPA, or Medicaid waiver authority² to establish risk- and prevention-based LTSS eligibility</p> <p>Rule change, MCO contract language, SPA to revise medical necessity criteria for individuals who receive LTSS</p> <p>Rule change, MCO contract change, SPA, waiver authority² to expand availability of LTSS-type services across all waivers</p> <p>Potential state legislative action</p> <p>Statute change to establish risk- and prevention-based LTSS eligibility; revise medical necessity criteria for individuals who receive LTSS</p> | NH DHHS, all LTSS programs and providers, Medicaid MCOs, NH legislature |
| Person-centered care planning, team coordinators, and health homes | New Hampshire's move to Medicaid managed care for LTSS populations envisions MCOs possibly taking on the health home role beginning in December 2014 | General LTSS population | <p>Proposed state executive branch action</p> <p>Rule change, MCO contract change to enable life plan planning and creation</p> <p>Rule change to authorize multi-payer team coordinator payments</p> <p>Rule change, MCO contract change, SPA to establish multi-payer Health Homes</p> <p>Potential state legislative action</p> <p>Statute change to authorize multi-payer team coordinator payments, multi-payer health homes</p> | NH DHHS, all LTSS programs and providers, Medicaid MCOs, NH legislature |

(continued)

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Appendix Table 16A-1. Models and strategies proposed in New Hampshire Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ | Entities that will be involved in implementation |
|--|---|-------------------------|---|---|
| Consumer-directed care with individual LTSS budgets and reimbursement accounts | HCBS waiver consumer-directed care and individual budgets | General LTSS population | <p>Proposed state executive branch action</p> <p>Rule change, MCO contract change, waiver authority² to expand consumer-directed care budgeting</p> <p>Rule change, MCO contract change, SPA, waiver authority² to increase provider quality and price transparency</p> <p>Rule change, MCO contract change, SPA, waiver authority² to operationalize reinsurance pool</p> | NH DHSS, all LTSS programs and providers |
| <p>Supporting strategies</p> <p>LTSS Incentive alignment with Public Health</p> <p>Substance-use disorder treatment alignment with LTSS</p> <p>Health IT</p> <p>Global Triple Aim Incentive Pool initiative</p> | <p>Medicaid Incentives for the Prevention of Chronic Diseases</p> <p>Build on existing HIT capabilities</p> | General LTSS population | <p>Proposed state executive branch action</p> <p>MCO contract change, SPA, waiver authority² to allow use of LTSS reimbursement accounts to incentivize participation in public health initiatives</p> <p>MCO contract change to include new substance use disorders benefit in LTSS</p> <p>Potential state executive branch action</p> <p>SPA, waiver authority² to include new substance use disorders benefit in LTSS</p> <p>Rule changes, MCO contract changes, SPAs, waiver authority,² Round 2 Model Test funds, BIP funds to enable shared savings to providers, payers, and infrastructure pool (health IT, workforce development)</p> <p>Potential state legislative action</p> <p>Statute change to allow LTSS providers access to state HIE</p> <p>Proposed federal action</p> <p>Round 2 Model Test award to support health IT expansion to LTSS providers</p> | NH DHSS, all LTSS programs and providers, public health agency, substance use providers, NH legislature |

(continued)

Appendix Table 16A-1. Models and strategies proposed in New Hampshire Health Care Innovation Plan (continued)

¹Policy levers include Medicaid waivers; federal grants (including Round 2 SIM award); state laws; state regulations; state investments (e.g., in public health programming); foundation grants; employer-led coalitions to drive change among providers, purchasers, or plans; state government–led coalitions, task forces, or commissions to drive voluntary change among providers, purchasers, or plans; state purchasing contracts; and state-level (Governor-initiated) executive policy directives.

²New Hampshire is in the process of developing a Medicaid section 1115 waiver application. It is unclear at this time which of the strategies included in the Plan that could be authorized by a waiver will be included in this waiver.

Abbreviations: BIP = Balancing Incentives Program, DHHS = Department of Health and Human Services, HCBS = home and community-based services, HIE = health information exchange, IT = information technology, LTSS = long-term services and supports, MCO = managed care organization, NH = New Hampshire, SPA = state plan amendment.

17. New York

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To develop its Health Care Innovation Plan (the Plan), New York organized a new group almost exclusively consisting of senior staff from several state agencies involved in the delivery and regulation of health care; McKinsey & Company provided support services in the last three months of the planning process. Although external stakeholders were not formally part of the Plan’s organizational structure, the state did engage some stakeholders on a targeted basis to “vet” major concepts as the Plan developed.

At the heart of the Plan is establishment of Advanced Primary Care (APC) as a universal model for statewide, multi-payer adoption. APC is a population health management model grounded in patient-centered medical home (PCMH) principles. A flexible framework is to be established for value-based payment under APC. Policy levers for Plan implementation include the state’s Medicaid section 1115 demonstration waiver, its Prevention Agenda 2013–2017, and regulatory changes to the health insurance and premium rate review processes. The Plan, to be phased in over a 5-year timeline, is projected to reach 80 percent of the state population with an integrated delivery model and 80 percent of the state’s health care spending contracted under value-based models. Net savings are estimated at \$5 to \$20 billion between 2015 and 2019.

The health care environment surrounding development of the Plan included, on the one hand, New York’s much higher than average health care costs combined with regional disparities and, on the other hand, a history of political commitment to health care reform combined with many health transformation initiatives already under way. The state’s 2012 State Innovation Models (SIM) Model Test application was focused more on Medicaid, with particular language for those with physical and mental disabilities. Using the SIM Model Pre-Test award that resulted from the 2012 application, New York has broadened the reach of the Plan to include more payers in an effort to reach the 80 percent goal and greater push for payment reform, while “not throwing [initiatives proposed in its 2012 Model Test application] off the table.”

17.1 Context for Health Care Innovation

As New York began its planning effort, many contextual factors influenced the state’s decision making in crafting the Plan. Chief among these were New York’s high health care costs, its low ranking on some quality measures, regional diversity in its health care markets, longstanding political support for health care reform, existing value-based reform efforts, and an articulated prevention agenda.

New York has one of the most costly health care systems in the nation, with 2009 per person spending 18 percent higher than the U.S. average (SHADAC, 2012). Although spending on physician services is comparable to that in the rest of the nation, hospital spending is considerably higher (SHADAC, 2012). Even with high health care spending, however, New York scores average on several quality measures and ranks 50th nationally for avoidable hospital use and 40th for hospital admission for ambulatory care–sensitive conditions (New York State Department of Health [NYSDOH], 2013a). Another distinct feature of the state’s health care market is its diversity. Particularly critical to the SIM Initiative, significant differences in physician practice arrangements exist across this geographically large state. Further, while New York has led the nation in PCMH adoption, the share of primary care providers participating in such an arrangement varies considerably by region, ranging from a low of 7 percent on Long Island to a high of 45 percent in the Albany–Northeast New York area in 2012 (Burke, 2012).

Yet another important contextual element for the Plan is New York’s longstanding commitment to health care reform. Many of the private health insurance market reforms included in the Patient Protection and Affordable Care Act (ACA), for example, had already been implemented in New York; in some cases, existing state law exceeded ACA-required standards (Coughlin et al., 2012). As one stakeholder observed, “[New York] is not afraid to regulate.” Similarly, because of the state’s tradition of sponsoring comprehensive public health insurance programs, New York’s ACA Medicaid expansion is relatively small. With an executive order issued by the Governor, New York is one of 17 states operating its own ACA health insurance marketplace for individuals (Kaiser Family Foundation, 2013). The Governor has also pushed to reform Medicaid. Soon after assuming office in 2011, he launched the Medicaid Redesign Team (MRT), which was charged with finding ways to reduce program costs and improve quality and efficiency (NYSDOH, 2014b). During the first phase of the MRT, some 200 initiatives had been implemented with estimated Medicaid savings totaling \$2.2 billion—including the Fully Integrated Dual Advantage (FIDA) Demonstration, the PCMH Incentive Program, and the Medical Home Demonstration Project (NYSDOH Web site, 2014b).

Apart from its Medicaid initiatives, New York has many other health transformation initiatives relevant to development of the Plan. Indeed, officials made an effort to build on these initiatives, particularly those focused on integrated, collaborative, and primary care. Stakeholders cited the Adirondack Medical Home Pilot—a 5-year, multi-payer demonstration launched in 2010 in rural northeastern New York—numerous times as an important source of information and experience in shaping the Plan. The Adirondack project was one of eight sites chosen by CMS in its Advanced Primary Care Practice Demonstration and involves essentially all primary care practices in the region (Burke and Cavanaugh, 2011). Other influential initiatives include the Finger Lakes Health Systems Agency, an independent community-based regional health planning organization that coordinates the local health care delivery system; physician practices participating in CMS’s multi-payer Comprehensive Primary Care Initiative;

and the P2 Collaborative in western New York, which provides community support to physician practices while also sponsoring consumers with self-management programs.

Another contextual feature of New York’s landscape pertaining to the Plan design effort is its Prevention Agenda 2013–2017. Created by the New York State Public Health and Health Planning Council at the request of NYSDOH (NYSDOH Web site, 2014c), the agenda serves as a blueprint for state and local action to improve the health of New Yorkers in several priority areas and to reduce health disparities (NYSDOH Web site, 2014c).

17.2 Planning Infrastructure and Process

Officials noted that the Governor’s Office had been “on board since the beginning” with the SIM Initiative, directing NYSDOH to submit an application to participate. However, because of an internal reorganization and departure of key project staff at NYSDOH, the planning infrastructure and process for the Plan occurred in two distinct waves. Model Design planning was initially the responsibility of NYSDOH’s Office of Health Information Technology Transformation (OHITT). After what was described as a “hiatus” in planning following the departure of a deputy commissioner who oversaw OHITT and served as the initial lead of the Plan process, the second wave of Model Design planning began in summer 2013, when Plan responsibility shifted to the Office of Quality and Patient Safety (OQPS). With this shift, Plan development began “in earnest” as one interviewee put it; it is this second part of the planning process that we primarily focus on here. Although most of the planning occurred within the NYSDOH, several other state agencies were involved to varying degrees. The approach to stakeholder engagement changed when the management of the SIM Initiative transferred from OHITT to OQPS. OHITT began with a broad outreach to stakeholders, including payers and providers, but when Plan responsibility was moved to OQPS, NYSDOH staff largely drove the design with the consultation of other state agencies and targeted stakeholders. As it developed the Plan, the state did, however, “vet” different versions with selected external stakeholders, principally providers and payers. The state completed two rounds of in-person stakeholder meetings in regions across the state—including Rochester, Buffalo, Syracuse, Albany, and New York City. But some stakeholders, including consumer advocates, were brought in late in the process, once a full draft Plan had been developed.

Governance and management. From April to June 2013, OHITT spearheaded New York’s Plan effort. In late summer, shortly after OQPS took over planning responsibility, the state hired McKinsey to support state staff in developing the Plan. With McKinsey’s help, state officials noted that planning ramped up quickly and a SIM planning structure was formalized that comprised almost exclusively state personnel, largely from NYSDOH but also from other state agencies. State officials detailed that, over the Model Design period, the Governor’s Office

was briefed on several occasions, providing feedback on the Plan. The legislature was not involved in any formal way.

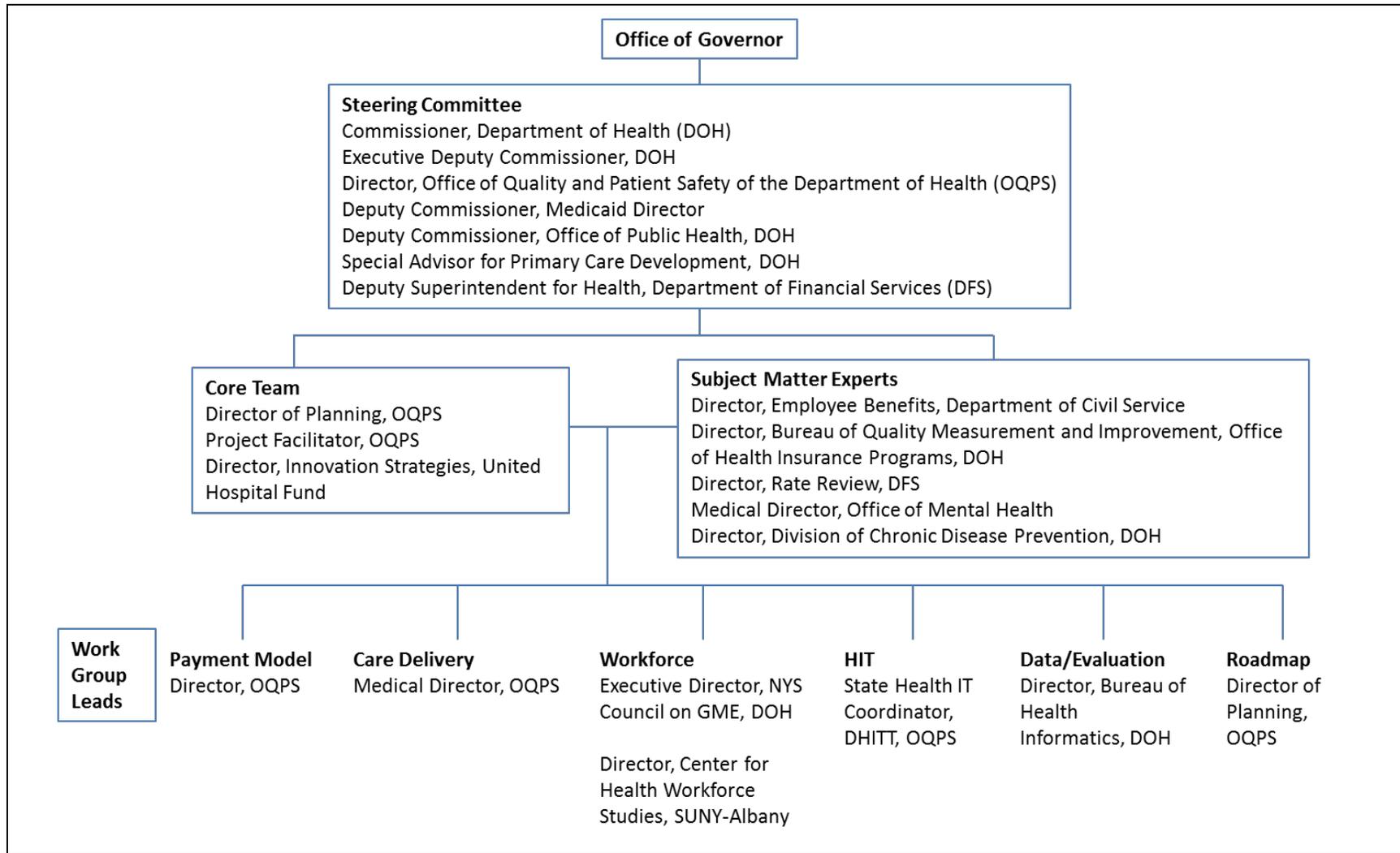
For the SIM Initiative, New York established a new organizational structure, the broad terms of which are displayed in *Figure 17-1*. The Steering Committee (the first tier of the structure) reported directly to the Governor's Office and led the effort. The Steering Committee included senior people from across NYSDOH and the Department of Financial Services (DFS), the state's regulatory agency for private health insurance. As one health infrastructure stakeholder noted, the Steering Committee represented "a remarkable show of force" in bringing together the most senior executives from various state offices.

Two groups formed the second tier of the planning structure to support the Steering Committee. One group was the Subject Matter Experts, which included representation both from within NYSDOH and from senior officials of other state agencies—including the Office of Mental Health (OMH) and the Department of Civil Services (DCS), which has responsibility for administering state employee health insurance. The second group was the Core Team, which included OQPS staff and a nongovernment consultant (not from McKinsey).

The third tier of New York's planning structure was organized into six work groups, using the topics from the SIM Initiative Model Design notice of award announcement as a guide—Payment Model, Care Delivery, Workforce, Health Information Technology (health IT), Data/Evaluation, and Roadmap. Each work group had at least one NYSDOH leader, along with assigned McKinsey staff to serve as analysts. Within these six functional areas, the state expert(s) and McKinsey staff would brainstorm about innovations New York could pursue. In some instances, McKinsey would help NYSDOH staff connect with other states that had implemented (or were considering) approaches under deliberation in New York. According to New York's October 30, 2013 quarterly report, state staff participation (those from both NYSDOH and other agencies) in all Plan activities was provided in-kind (NYSDOH, 2013b). New York did not allocate additional funds, nor did it receive any outside funding to support the effort.

Stakeholder engagement. The approach to stakeholder engagement changed somewhat when Plan management transferred from OHITT to OQPS. OHITT began with a Webinar in the spring of 2013 in which a broad array of stakeholders participated. Then OHITT conducted a series of meetings in different regions of the state where it met in person with local stakeholders. Additionally, OHITT arranged a series of meetings, both one on one and in groups, in which external stakeholders (e.g., payers, plans, providers, and regional health planning organizations) were asked for their input on core ideas the state was considering including in the Plan. An additional Webinar and conference calls were also held. OHITT also had conversations with selected state agencies outside NYSDOH.

Figure 17-1. New York State Health Care Innovation Plan organizational chart



*Adapted from State Innovation Models (SIM) Quarterly Progress Report for New York State, October 2013.

Once planning shifted from OHITT to OQPS, the Steering Committee developed basic pieces of the Plan. Then, OQPS engaged selected stakeholders for their input on and reaction to particular parts of the Plan; these stakeholders included health plans, regional planning associations, and industry representatives of providers and employers. OQPS staff, along with McKinsey, further developed the Plan and consulted payers, health care infrastructure stakeholders, providers, and various other stakeholders on an ad hoc basis. In multiple iterations, select external health care stakeholders (the “usual suspects,” as one state official described them) were engaged in “small, targeted discussions” with state officials to vet different versions of the Plan in an effort to reach consensus. One state official described the stakeholder process as a “two steps forward, one step backward” approach. And one official “guessed” that 40 versions of the Plan were drafted during this phase.

As OQPS went through this iterative process with external stakeholders, it also vetted the different versions with internal state stakeholders (such as DFS, DCS, and OMH). The idea behind this iterative approach was to “be 80 percent down the road” before it released the Plan to the broader New York stakeholder community. The intensity with which entities met varied as the Plan was developed. The Steering Committee, for example, generally met every 2 to 3 weeks but sometimes met on a weekly basis as Plan development demanded. Work group working sessions were even more frequent, meeting 1 to 2 times a week.

On November 15, 2013 New York released the Plan, inviting public comment for a 2-week period. At this point, OQPS staff and other state personnel met with a range of stakeholders (e.g., payers, providers, consumer groups, community organizations, and regional planning groups) to solicit their thoughts. During the rest of November, state officials hosted regional meetings with stakeholders across the state, in partnership with leaders in those regions, to discuss the Plan and receive further feedback. Although some stakeholder groups expressed disappointment about being brought in late to the process, having only “conceptual input,” or being excluded altogether, others observed that major elements of the Plan are based on initiatives or ideas that had been discussed by a wide range of New York health care stakeholders in recent years.

Some stakeholders were missing from the Plan development process, as state officials confirmed. Consumer organizations, for example, were brought in only when the draft Plan was released, but NYSDOH directly contacted them and encouraged them to comment. Officials noted that although they spoke with industry groups representing employers, they wished they had more representation from employers directly. In addition, some outside stakeholders engaged by the state in Plan development commented that, because their discussions with the state tended to be circumscribed, they did not see the Plan’s “big picture” until the Plan was released for public comment.

17.3 The New York Plan

New York is one of the three Model Pre-test states. In crafting the Plan, state officials noted that they did not discard initiatives put forth in their initial proposal, which was acknowledged as “Medicaid centric.” Instead, as noted, officials explained that they broadened the ideas and strategies presented in their initial proposal to include more payers, so the Plan would be consistent with what they think CMS is looking for in a Plan.

The Plan proposes to implement a PCMH model and several supporting strategies, all organized around five strategic “pillars”: improving access, integrating care, making health care cost and quality transparent, paying for value not volume, and connecting health care with population health. The pillars are supported by three cross-cutting “enablers” of system transformation—investment in workforce, health IT, and performance measurement and evaluation. *Figure 17-2* provides more detail on each of these Plan components.

Figure 17-2. New York State Health Care Innovation Plan pillars and enablers

| | 1 | 2 | 3 | 4 | 5 |
|-----------------|---|---|--|--|--|
| Pillars | <p>Improve access to care for all New Yorkers, without disparity</p> <p>Elimination of financial, geographic, cultural, and operational barriers to access appropriate care in a timely way</p> | <p>Integrate care to address patient need seamlessly</p> <p>Integration of primary care, behavioral health, acute and post-acute care; supportive care for those that require it</p> | <p>Make the cost and quality of care transparent to empower decision making</p> <p>Information to enable consumers and providers to make better decisions at enrollment and point of care</p> | <p>Pay for healthcare value, not volume</p> <p>Rewards for providers who achieve high standards for quality and consumer experience while controlling costs</p> | <p>Promote population health</p> <p>Improved screening and prevention through closer linkages between primary care, public health, and community-based supports</p> |
| Enablers | <p>A Workforce strategy: Matching the capacity and skills of our healthcare workforce to the evolving needs of our communities</p> | | | | |
| | <p>B Health information technology: Health data, connectivity, analytics, and reporting capabilities to support clinical integration, transparency, new payment models, and continuous innovation</p> | | | | |
| | <p>C Performance measurement and evaluation: Standard approach to measuring the Plan’s impact on health system transformation and Triple Aim targets, including self-evaluation and independent evaluation</p> | | | | |

*Adapted from New York State Health Innovation Plan, December 2013.

The heart of the Plan involves establishment of APC as a universal model for statewide, multi-payer adoption. Under the Plan, New York proposes to establish a flexible framework for value-based payment under the APC model. Primary policy levers for Plan implementation include the MRT amendment to the state’s Medicaid section 1115 waiver, its Prevention Agenda 2013–2017, and regulatory changes to the health insurance processes. Implementation is also

reliant on a number of executive branch or voluntary actions in the public and private sectors, involving (among others) health care payers, providers, and community-based organizations.

In addition, the Plan involves several strategies to build infrastructure to support APCs and population health more broadly. Together, the Plan’s strategies are designed to affect the health care delivery system for at least 80 percent of the state’s population. More specifically, an overarching Plan goal is that 80 percent of New Yorkers be in a recognized integrated care model (and receiving care under a value-based payment arrangement) within 5 years.

17.3.1 Models and Strategies

The Plan proposes innovations in the following categories: (1) advanced primary care, (2) value-based payment models, (3) public reporting, (4) infrastructure to support delivery system transformation, (5) workforce development, (6) enhanced data analysis, (7) health IT, (8) consumer engagement for better health management, and (9) value-based insurance design. Each is described below. *Appendix Table 17A-1* provides a summary description of the innovations, initiatives on which they are built, populations they address, and supporting policy levers and entities.

Advanced primary care. The APC model, a keystone of the Plan, is the primary means for providing integrated care to New Yorkers—the Plan’s second strategic pillar. The model builds on principles embodied by the National Committee on Quality Assurance (NCQA)–certified PCMH, but goes beyond those standards by specifying processes and outcomes associated with integrated care—such as prevention, effective management of chronic disease, and coordination among the full range of providers working together to meet consumer needs. Integration with behavioral health is a major component, to be promoted through statewide rollout of the Collaborative Care approach (which aims to detect and manage common mental health conditions in primary care settings) in the most advanced APC practices (NYSDOH, 2013a).

All state-licensed providers would be eligible to implement APC. The model is intended to represent “an evolution” toward stronger integrated care and to fit with providers’ and payers’ existing priorities and innovations. For instance, the Plan envisions that the process through which providers would become eligible for APC would be based in part on preexisting medical home recognition (such as through NCQA) to minimize the administrative burden on providers. In addition, to encourage innovation, the Plan leaves many operational details of APC models (e.g., which care coordination or practice transformation models will be used) to be determined at the local or regional level. New York will, however, pursue statewide standardization in a few major areas—including the definition of key metrics, reporting requirements, health IT interoperability, and overarching practice standards for participation.

Support for practice transformation is an important part of the APC model. The Plan proposes that the state encourage development of regional support models to assist with practice transformation and convene shared resources for care coordination; these entities would build on collaborative arrangements such as those in the Finger Lakes and Adirondack regions, but would also seek to leverage county health departments and the newly proposed Regional Health Improvement Collaboratives (RHICs) (see below).

Recognizing the diversity of practices within the state and the varying levels of support they would need, the Plan describes a graduated path with three progressively advanced levels of integrated care: Pre-APC, Standard APC, and Enhanced APC. The state expects all major payers to participate in the APC model—including Medicaid, Medicare, commercial payers, and the state employees' health insurance plan (called 17-SHIP). Transformation to universal APC would require significant commitment from all payers involved, including resources and funding for care coordination and practice transformation support.

Finally, the APC model and the accompanying spectrum of value-based payment models (described below) is to complement New York's current or emerging integrated care models, which are focused on populations requiring extended care coordination that primary care physicians (PCPs) at present cannot deliver. The care of such populations would be the responsibility of Medicaid, through efforts such as Medicaid health homes and the FIDA demonstration.

Value-based payment. The Plan's fourth strategic pillar, paying for value not volume, calls for widespread use of value-based payment models, to be implemented via the APC approach. Overall, the Plan intends to move payment models across all payers from pure fee for service to arrangements that align payment with health system goals and increase provider accountability for outcomes and total cost of care.

Rather than deploying standardized specific payment arrangements, in an effort to promote innovation, the Plan aims to define a spectrum of models (potentially organized according to the three graduated APC levels), so payers can determine the detailed design and distribution of models they will implement. The models on the spectrum would range from pay for performance to capitation and other kinds of risk-sharing arrangements. This flexible approach is responsive to the diversity of value-based payment models already being piloted in New York, of which (according to the Plan) there are more than 100. Particularly notable current or emerging models include the ACA-authorized Pioneer accountable care organization model intended to help providers move from fee for service to full risk/global budget arrangements and two models in the MRT waiver amendment—the Delivery System Reform Incentive Payment Program, which includes performance-based payments for reducing inappropriate hospitalizations, and the FIDA program, which will transition dually eligible beneficiaries into new managed care programs.

Public reporting. Important to achieving the Plan’s third strategic pillar, the Plan aims for statewide transparency of a core set of quality, utilization, and cost metrics. These metrics would be available at the facility and practice levels, through a consumer-targeted Web site intended to enable consumer action and shared decision-making. Development of the “transparency portal” is already under way, supported by the state’s recent Cycle III rate review grant from CMS. The Plan also proposes a series of activities that would raise awareness of and educate consumers and other stakeholders about using the portal.

Infrastructure to support delivery system transformation. The fifth strategic pillar in the Plan involves promoting population health by facilitating connections among primary care, hospitals, local health departments, and a variety of community stakeholders. NYSDOH’s Prevention Agenda 2013–2017 serves as a guide for this Plan component, which aims to provide APCs with incentives and tools to be effective partners in implementing the agenda’s related population health improvement plans. One key strategy is to strengthen linkages between primary care practices and community resources, which would be facilitated by local regional resource centers and health planning organizations—RHICs that are newly proposed in the Prevention Agenda.

High-quality community resource registries would also be created under the Plan, which would connect primary care practices and community-based organizations or partnerships focused on health prevention or improvement, and work to ensure PCPs have the information necessary to link their patients to supportive community organizations.

Workforce development. An adequate and appropriately trained health care delivery workforce is foundational to the Plan, and thus identified as one of its three “enablers.” The Plan’s workforce-related strategy builds on components of the MRT agenda, with the objective of refining and expanding programs meant to balance workforce supply and demand across a full spectrum of clinical capabilities—particularly those required under the new APC model. The four areas of focus for the Plan’s workforce strategy are to: (1) improve attraction of the primary care workforce to (and their retention in) underserved areas; (2) update standards and educational programs for all types of health care workers to reflect needs involved in delivering the APC model (e.g., training in care coordination or multidisciplinary teamwork); (3) establish infrastructure to test workforce models of care where professionals work closer to the top of their licenses; and (4) develop more robust data and planning capacity to ensure adequate primary and specialty care workforce supply.

Enhanced data analysis. A standardized, statewide approach to measuring and evaluating health care delivery is among the Plan’s three enabling factors. The Plan’s two objectives in this area are to: (1) measure progress of the Plan in achieving its goals and statewide health system transformation, and (2) monitor how the APC progresses toward improving quality, reducing costs, and improving health for patients, providers, and payers. The

Plan proposes a “standard scorecard,” which would contain a selection of metrics from existing sources (including but not limited to the MRT, health plans, and the Prevention Agenda), and which would be used as the basis for all Medicaid and 17-SHIP contracts and—increasingly—for commercial contracts. The Plan intends to finalize the core set of metrics by July 2014.

Enhanced health system data analysis and reporting is dependent on New York’s evolving health information exchange architecture (called the Statewide Health Information Network for New York or SHIN-NY). SHIN-NY is intended to provide core analytic and reporting capabilities to measure payer- and provider-level outcomes (including the standard scorecard measures described above) under APCs and the value-based payment models. It also involves implementation of the state’s All Payer Database (APD, the term used in New York for its all payer claims database). Broad participation in the APD is a major part of the Plan’s fourth strategic pillar—paying for value not volume—and APD data are necessary for the creation of decision support and transparency tools for consumers, providers, and payers.

Health IT. The Plan includes a number of activities to facilitate health care providers’ connections to New York’s growing technological infrastructure and ensure broad participation in health IT initiatives. Health IT is one of the three enabling factors for implementation of the Plan. It proposes, for instance, regulations that would require EHR systems to connect to a Regional Health Information Organization (RHIO), and legislation that would ensure linkages between certified EHR systems and SHIN-NY.

Consumer engagement for better health management. In addition to promoting the consumer-focused transparency portal used for public reporting, the Plan proposes several activities to stimulate use of a patient EHR portal, where all New Yorkers would have access to their own personal electronic health record (EHR). Development of such a portal is currently under way, led by the New York eHealth Collaborative. Plan activities range from regulatory changes that would permit laboratory results to be automatically populated in the patient portal to facilitating the design and development of portal-related consumer engagement tools and applications by third parties.

Insurance benefit design. Under the Plan, New York will encourage broad use of value-based insurance design (VBID), a concept that is gaining traction in the state but has not yet been pursued in any widespread or comprehensive manner. Drawing from the experiences of states like Connecticut, the Plan’s strategies for promoting VBID involve stakeholder engagement and education, identification of best practices in VBID, and consideration of a VBID opt-in program for state employees (under the 17-SHIP plan) that would launch in 2015.

17.3.2 Policy Levers

Policy levers are listed in *Appendix Table 17A-1*. The most significant policy ones are discussed here, but the table contains additional policy levers that may facilitate implementation. A primary policy lever for the Plan is New York’s MRT agenda, which, among other things, defines a path to integrated care for the state’s Medicaid program. The transformation envisioned by the MRT will be carried out under an amendment to the state’s Medicaid section 1115 waiver. The Plan builds on the MRT blueprint, and a number of its elements rely on the funding from the approved waiver amendment.

New York’s Prevention Agenda 2013–2017 represents another important policy lever already in place. The Plan complements the Prevention Agenda by providing a practical vehicle for state agencies, payers, providers, and other stakeholders to implement its major objectives. For instance, several of the Prevention Agenda’s objectives (e.g., offering systemic screening and disease management for diabetes, obesity, and other chronic diseases) align with activities for which APC providers (under the Plan) would be held accountable; the Prevention Agenda proposes a series of metrics for assessing progress toward these objectives, which are incorporated into the Plan’s draft standardized scorecard. In addition, the RHICs called for by the Prevention Agenda are expected to facilitate local health planning and have been identified as potential resource centers for providers undergoing practice transformation to become APCs. Although the Prevention Agenda itself is not a funding mechanism, it would provide leverage for implementing the Plan, because it represents a path toward improving population health that has the approval of the state administration and the many stakeholders who participated in its development (e.g., provider groups, consumer advocates).

A third key policy lever for the Plan involves changes to processes used by DFS to regulate health insurance products—in particular the policy form approval (i.e., the process of reviewing insurance policies to ensure they cover mandated benefits and meet other state requirements), health maintenance organization licensure renewal, and premium rate review processes. Although the specific details of how these processes will be changed, or what may be newly required of the health insurance carriers they target, is not fully delineated in the Plan, it does indicate that, as part of the refined DFS regulatory processes, “payers will have an opportunity to report on how their provider portfolio is distributed against value-based payment models including the three APC levels and to describe the penetration over time of value-based payment models and VBID.”

Regarding legislative action as a policy lever for the Plan, state officials indicated that new legislation would not be required to make changes to the DFS processes described above. New regulations or legislation may be required to capture and use data via the APD and SHIN-NY, according to the Plan. And existing legislation—the 2000 Health Care Reform Act (HCRA)—may play an important role in implementation. HCRA authorized surcharges and

assessments on certain third-party health care payers and providers; HCRA revenue has been used to fund a multitude of health care initiatives and represents a potential sustainable funding source for the RHICs, RHIOs, and the APD.

The Plan also relies heavily on actions by the executive branch across each of the proposed innovations. In addition, successful implementation is dependent on voluntary action by health care payers. Among other activities, payers are responsible for the detailed design, testing, and adoption of payment models (working in concert with providers); resources and support for the care coordination and practice transformation required under the APC (and associated value-based payment) model; and implementation of high-impact VBID into their health plans (in particular, the Plan indicates that Medicaid and 17-SHIP may take a lead role in this effort). Other voluntary changes will be required at the provider level, to pursue certification as an APC practice and to adopt the health IT necessary to participate in system transformation.

17.3.3 Intended Impact of the Plan

Broadly, the Plan intends to achieve improved health, better health care quality and consumer experience, and lower costs. A cascaded series of targets and metrics support these overarching goals. They include 80 percent of New Yorkers receiving care through an integrated delivery model (such as APC or the emerging integrated care models APC complements), a majority of PCPs connected to regional registries of community resources, an increase in providers using health IT, and 80 percent of health care spending statewide contracted under value-based payment models. Given the strong foundation for many of the innovations included in the Plan and its reach, all stakeholder groups agreed that, as designed, it had the potential to affect the targeted 80 percent of New Yorkers.

According to the financial analysis included in the final version of the Plan, if fully implemented, New York's Plan would create \$15 to \$20 billion in savings through reductions in waste and inefficiencies. After accounting for reinvestments in the system (e.g., provider incentives, practice transformation and health IT support), an estimated \$5 to \$10 billion in net savings from 2015 to 2019 is projected, with the potential to reduce the annual increase in health care spending by 1 to 2 percentage points by 2019 (NYSDOH, 2013a).

17.3.4 Proposed Next Steps

The state proposes a 5-year timeline in which the Plan would be rolled out in several phases. During Phase 1, the state would create the delivery and governance mechanisms for implementing the Plan and ensure the necessary funding is in place. Several operational decisions also would be made during this phase—including how practice transformation is to be supported and how the health insurance premium rate review process is to be adjusted to encourage use of value-based payment models. In Phase 2, the state would establish the foundation for the APC model. Any state regulation or legislation required to capture and use

data via the APD and SHIN-NY would also be pursued during this phase. During Phase 3, APC recognition and the enhanced rate review process would begin, and the transparency tools and public reporting mechanisms rolled out.

Given the Plan's intention to use a variety of funding sources to carry out implementation, New York plans to launch the Phase 1 of this process in 2014, "with or without SIM Round 2 funding," according to one stakeholder involved in developing the health care system infrastructure. Many Plan elements rely on successfully obtaining MRT Medicaid section 1115 demonstration funds; on February 13, 2014, the state announced that CMS had agreed to fund \$8 billion of the \$10 billion requested over 5 years (Hartocollis, 2014).

17.4 Discussion

The stakeholders described New York's Plan as a "natural progression" in a direction that the state was already headed, only now with an articulated vision. While acknowledging that the goals are ambitious, stakeholders felt that the forces were aligning to support successful implementation—that, in addition to a foundation of existing initiatives such as the MRT section 1115 waiver, these include strong and active state leadership and the state's willingness to use regulatory tools to influence insurance carrier behavior.

17.4.1 Critical Factors Shaping the Plan

Several factors were said to influence development of the Plan. A key one was the existing policy environment and health care market. Indeed, in choosing to make primary care (advanced through the APC model) the centerpiece of the Plan, officials stated that this was driven in part by recognition that New York has been "overinvested in specialty and institutional care and underinvested in primary care." Also, they reportedly looked at what was "working in reality" across the many initiatives operating in the state and nationally, and determined that primary care demonstrations were most likely to make them successful in reaching their goals.

State officials' engagement was also seen as important. One state stakeholder mentioned that a gubernatorial push to reform the state's health care system, and to encourage agencies and the private sector to find their "way to each other," also shaped the Plan. Although NYSDOH drove Plan development, significant and important input from other state agencies—including DFS, OMH, and DCS—was described as essential to shaping the Plan.

The process New York used to engage stakeholders in Plan development was recognized as different from other recent health care policy discussion (e.g., the MRT effort)—a distinction driven in part by the shorter and more compressed planning time frame—particularly because of the organizational change within NYSDOH that resulted in OQPS taking over responsibility for the Plan roughly halfway through the Model Design period. Consumer representatives felt

particularly left out of the Plan’s development and noted that it was a “real departure” from how NYSDOH generally conducts business. At the same time, they recognized that NYSDOH staff is “hardworking” and “dedicated” and felt that this “out of character” process could be attributed to the organizational shift that occurred in the summer. Although supportive of the Plan’s general goals, one consumer group felt the Plan was lacking in consumer engagement and assistance.

17.4.2 Lessons Learned

As it pertains to facilitating a stakeholder process for developing something akin to the Plan, New York stakeholders, while noting that every state is different, offered several lessons learned:

- **Find the highest level of agreement across stakeholders and then work down.** As one interviewee stated, “Stakeholders often agree at the highest level; it is at a lower level where it is hard.” As part of that process, identify both stakeholders’ “pain points” and what they are currently satisfied with. Make the intentions and goals of the process clear from the outset.
- **Work within a broad population health framework.** This principle can spur interest and participation by a similarly broad group of stakeholders. When New York developed its initial SIM application, its focus was primarily on Medicaid initiatives and lacked the overarching vision for population health improvement, according to officials.
- **Start the planning process as early as possible.** This will allow stakeholders to develop and provide feedback on multiple iterations of the Plan, which can help prevent the Plan from, in the words of one stakeholder, getting “voted off the island.”
- **Costs and benefits matter.** In New York, the Plan development process revealed that figuring out the costs and returns on investment associated with different strategies early in the process can be instrumental in obtaining stakeholder support. Representatives of employer and health plans expressed apprehension about committing to a plan without knowing exactly what would be required of them.
- **Build on existing models.** The leaders of the Plan development process identified existing models in the state that evidence indicated would yield success early on, and used them as part of the argument for moving forward with a bigger initiative. New York’s success with the Adirondack Pilot, for example, was cited as a reason to believe the APC model could be successful.

17.4.3 Potential for Implementation

Most stakeholders felt that New York’s Plan was feasible, in large part because it builds on a foundation of innovations currently under way in the state, including a host of PCMH and

value-based payment pilot projects, health IT infrastructure-building, and performance measurement. But despite positive feelings about its overall feasibility, various stakeholders described a number of challenges to Plan implementation. Chief among these was potential lack of resources. Although a few questioned whether NYSDOH had the staffing capacity to carry out implementation within the ambitious 5-year timeframe (particularly given the agency's many competing priorities), most were concerned about funding for the Plan. According to the state's financial analysis, the Plan will cost \$1.5 billion (over 5 years) to implement. In addition to an estimated \$500 million for workforce development already requested as part of the MRT section 1115 waiver and \$200 million in funding for health IT—for which HCRA tax revenue and other funding sources are currently being contemplated (New York State Department of Health Web site, 2014a and 2014b)—this includes an estimated \$0.8 billion investment by payers to implement the APC model.

The significant investment expected on the part of payers, and the Plan's expectation that virtually all payers in the state will participate, were also considered major challenges for implementation. For instance, some stakeholders noted the difficulty of incentivizing self-insured health plans to participate, because these plans are not regulated by DFS. Others suggested that large national plans (which have products in other states) might be reluctant to adopt New York-specific health IT platforms or performance metrics. At the same time, the Plan has received a uniformly positive response and constructive input from the leading payers (and industry associations) operating in the state, most payers participating in the state are already supporting similar initiatives, and many have had success in multi-payer initiatives.

Although lack of resources and achieving widespread payer participation were the most commonly mentioned barriers to implementation, others included (but are not limited to) existing licensing and regulatory barriers to behavioral health and primary care integration, gaps in the health care workforce, uneven use of health IT, engaging solo or very small practices in APC transformation, and obtaining union support for VBID. Many of these challenges are acknowledged in the Plan itself, although at this stage there are limited details about the strategies that will be used to address them.

17.4.4 Applicability to Other States

The models and strategies in New York's final Plan seem sufficiently generic that they could be applied nearly anywhere. That said, the specific initiatives selected were informed by New York's circumstances. For example, the need to implement a regional-based approach may be appropriate in a large, geographically diverse state like New York, but it might not be in a small state. Also, stakeholders noted, New York has a tradition of using regulation, which may not be the situation in other states.

17.4.5 Limitations of This Evaluation

Stakeholder interviews for this case study report were conducted between October and December 2013, before the Plan was finalized, and may not reflect stakeholder opinions of the content of the final Plan.

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Appendix Table 17A-1. Models and strategies proposed in New York’s Health Care Innovation Plan

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|--|---|--|---|--|
| <p>Advanced Primary Care Key features: Incorporates concepts of integrated care (including Collaborative Care model of providing behavioral health services in primary care setting) Based on three progressively advanced levels of integrated care (pre-APC, Standard APC, and Enhanced APC) Eligibility process grounded in preexisting PCMH approaches such as NCQA or CPCi</p> | <p>Adirondack Medical Home Demonstration (Medicare Multi-payer Advanced Primary Care Practice Demonstration) FQHC Advanced Primary Care Demonstration Medicare Comprehensive Primary Care initiative Several additional PCMH-like models operated by public and private payers CCI of NYS, particularly the approach to primary and behavioral health care integration P2 Collaborative of Western New York Prevention Agenda 2013–2017</p> | <p>Commercial patients (all) Medicare patients (except those served by LTC or FIDA care delivery model) Medicaid patients (except those served by health home or LTC delivery model)</p> | <p>Existing *Medicaid Redesign Team (MRT section 1115 waiver – in process) Federal Demonstration awards: Medicare Multi-payer Advanced Primary Care Practice, FQHC Advanced Primary Care Potential regulatory actions *Explore use of premium rate review process as mechanism to encourage APC (and associated value-based payment) model adoption Proposed regulatory actions Address regulatory constraints to integration of primary care and behavioral health (currently under way) Proposed executive branch action *Establish streamlined process for APC recognition *Determine organizational structures (likely regional), funding processes, and mechanics of supporting practice transformation Develop mechanisms for supporting collaboration among providers Increase financial or operational support provided from payers to providers for care coordination activities *Establish standardized scorecard for assessing APC performance</p> | <p>NYS DOH Office of Mental Health Payers, including Medicaid (administered by the DOH Office of Health Insurance Programs), 17-SHIP (administered by the NYS DCS, Medicare, and Private Payers) Providers</p> |

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Appendix Table 17A-1. Models and strategies proposed in New York’s Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|---|---|--|--|--|
| <p>Value-based payment models (implemented through the APC approach)</p> <p>Move all payers away from pure FFS arrangements and promote widespread use of value-based payment models</p> | <p>At least 100 value-based payment pilot programs have been implemented by public and private payers in New York; one major effort is the Pioneer ACO effort developed under ACA authority, which involves moving from FFS to a full risk/global budget arrangement</p> <p>The MRT section 1115 waiver includes value-based payment approaches such as the DSRIP, which targets safety-net providers, and FIDA</p> | <p>General population (with Medicaid and 17-SHIP leading initial adoption)</p> | <p>Existing</p> <ul style="list-style-type: none"> *MRT section 1115 waiver (in process) *Federal grant award: Cycle III Rate Review <p>Future regulatory actions</p> <ul style="list-style-type: none"> Define minimum threshold of what constitutes a value-based payment model *Create detailed design and technical requirements for value-based payment *Refine health insurance regulatory processes (premium rate review, HMO licensure renewal, certification of QHPs in the marketplace) to request information from payers on investments in value-based payment *Explore use of premium rate review process as mechanism to recognize payers’ value-based approaches and encourage adoption of value-based payment <p>Proposed executive branch actions</p> <ul style="list-style-type: none"> Work with CMS to: <ul style="list-style-type: none"> Explore how Medicare care coordination funding (draft rule pending) and other enhanced funding could be used to support APCs and value-based payment models Develop flexible framework for Medicare providers to participate in shared savings and risk-sharing models tied to total cost of care Aggregate data with those of other payers using the APD Standardize provider performance reports | <p>DOH (including Medicaid)</p> <p>DFS</p> <p>DCS</p> <p>Other payers</p> <p>Providers</p> |

(continued)

Appendix Table 17A-1. Models and strategies proposed in New York’s Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|---|---|---------------------------|---|---|
| <p>Public reporting Promote consumer-targeted “Transparency Portal” aimed at enabling consumer action and shared decision-making Includes development of portal informed by focus groups</p> | <p>Health Data NY, an effort to post health information on a public Web site Cycle III Rate Review Grant from CMS, supporting (among other things) creation of an interactive web-based query tool that will provide consumers, providers, and payers access to cost, quality, and premium information in an easy-to-use format.</p> | <p>General population</p> | <p>Existing *Federal grant award: Cycle III Rate Review Executive Order 95 to make additional data public and link all public data to its backup dataset (March 2013, led to Health Data NY) Proposed executive branch action Marketing and outreach effort to promote portal use</p> | <p>DOH (particularly the Office of Quality and Patient Safety) DFS Payers Providers Community-based organizations</p> |
| <p>Infrastructure to support delivery system transformation Strengthen linkages between primary care practices and community resources Promote the development and implementation of RHICs Create community resource registries Develop population health reports and routinely share them with APCs Link registries to Web-based tools</p> | <p>Prevention Agenda 2013-17 Community, Opportunity, and Reinvestment initiative sponsored by Governor’s Office</p> | <p>General population</p> | <p>Existing *Prevention Agenda 2013–2017 AHRQ’s Innovations Exchange (reports and tools for successful clinical-community collaborations) State facilitation of system change *Incentivize and encourage leadership from enhanced APC practices to participate in community health assessment and community service planning, potentially through RHICs *Build and maintain community resource registries Create formal communication channels between local health planning stakeholders and APC</p> | <p>DOH Providers Regional health planning organizations Community-based organizations</p> |

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Appendix Table 17A-1. Models and strategies proposed in New York’s Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|---|--|-----------------------|--|---|
| Workforce development Ensure an adequate and appropriately trained health care delivery workforce | MRT section 1115 waiver-related efforts to increase physician and nonphysician PCP supply in underserved areas (including Doctors Across New York program); build capabilities through the Health Workforce Retraining Initiative and other technical assistance programs; establish a Health Workforce Data Repository; and support health services research examining different workforce staffing models DOH-SUNY (and others) partnership to conduct regional workshops related to workforce planning | N/A | <p>Existing</p> <ul style="list-style-type: none"> *MRT section 1115 waiver funding (in process) <p>Potential regulatory action</p> <ul style="list-style-type: none"> Explore modification of clinical education admission criteria Consider extension and expansion of ACA Medicaid enhanced payment program for primary care providers Ensure that practice and privacy regulations enable use of telehealth Consider data reporting requirements for clinician registration/licensing renewal applications <p>Proposed executive branch actions</p> <ul style="list-style-type: none"> Incentivize and support rural hospitals and health centers to create residency and other training programs Test approaches to increase in-state retention post-residency Expand planned technical assistance program for Medicaid Provider hospitals to all providers for appropriate fees Develop a more sophisticated measure of “access” that goes beyond coverage and capacity <p>State facilitation of system change</p> <ul style="list-style-type: none"> *Incorporate targeted training in both Practice Transformation and Care Coordination into curriculum of health education institutions Payers to align provider compensation to care provided via telehealth methods | DOH Federal government (CMS) Health education institutions Payers Providers |

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Appendix Table 17A-1. Models and strategies proposed in New York’s Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|---|---|-----------------------|--|---|
| <p>Enhanced data analysis Create a standard, statewide approach to measuring and evaluating health care delivery Build on and expand existing health IT initiatives that are necessary for enhanced data analysis and reporting (SHIN-NY, APD)</p> | <p>Quality Assurance Reporting Requirements, a standardized set of metrics initiated in 1995 and required across commercial HMOs, PPOs, and Medicaid/CHIP managed care Quality indicators established in the MRT evaluation plan Metrics from the Prevention Agenda 2013–2017, and measures included in other state-supported evaluation programs SHIN-NY APD</p> | <p>N/A</p> | <p>Existing State investment in ongoing health IT development (including the APD and SHIN-NY), which reinforces the capacity for statewide measurement and reporting Proposed regulatory actions Develop technical requirements for measurement and evaluation infrastructure Proposed executive branch actions Lead collaborative process to develop consensus about core set of metrics to evaluate Plan and APC model (draft set created) Establish core metrics Publicly post results from semiannual evaluation of statewide health system transformation on state-sponsored Web site Post on a secure provider-access only Web site results from annual evaluation of the APC model, with initial provider-level APC performance results available; develop approach to share provider performance results publicly in future</p> | <p>DOH Payers Providers</p> |

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Appendix Table 17A-1. Models and strategies proposed in New York’s Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|--|---|-----------------------|--|--|
| <p>Health IT</p> <p>Facilitate health care provider linkages to growing technological infrastructure</p> <p>Promote provider participation in health IT initiatives, particularly SHIN-NY and APD</p> | <p>SHIN-NY</p> <p>APD</p> <p>Efforts to create EHR interoperability standards</p> | <p>N/A</p> | <p>Existing</p> <p>*2006 Health Care Efficiency and Affordability Law for New Yorkers</p> <p>Federal Meaningful Use incentive program</p> <p>2011 legislation allowing for creation of an APD (post-adjudicated claims); relevant regulations currently in development</p> <p>Potential legislative actions</p> <p>*Consider introducing legislation ensuring that certified EHR systems connect to SHIN-NY</p> <p>Proposed regulatory actions</p> <p>Create suite of regulations requiring certified EHR to connect to a RHIO</p> <p>State facilitation of system change</p> <p>Develop and provide ‘dial tone services’ (e.g., look up patient records, message securely, receive ER, inpatient, and outpatient event notifications) to all qualified entities via the SHIN-NY</p> <p>Develop and provide member-facing services (e.g., legal and information-sharing agreements, user training and support) to all qualified entities via the SHIN-NY</p> | <p>DOH</p> <p>Payers</p> <p>Providers</p> |

(continued)

Appendix Table 17A-1. Models and strategies proposed in New York’s Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|--|---|---------------------------|---|--|
| <p>Consumer engagement for better health management</p> <p>Stimulate use of “Patient EHR Portal” (currently in development)</p> | <p>New York e-Health Collaborative’s <i>Patient Portal for New Yorkers</i> initiative</p> | <p>General population</p> | <p>Existing</p> <p>*2006 Health Care Efficiency and Affordability Law for New Yorkers</p> <p>Potential regulatory action</p> <p>Consider developing guidance to permit laboratory results to be automatically populated on patient EHR portals</p> <p>Proposed regulatory action</p> <p>Define and disseminate the minimum technical requirements for third-party consumer engagement tools</p> <p>*Review and address existing regulatory statutes that may unnecessarily hinder innovation in creating consumer engagement tools and applications</p> <p>State facilitation of system change</p> <p>Create forums to convene stakeholders around issues related to consumer engagement and the patient EHR portal</p> <p>Ensure access to data for private payers, providers, or other third parties so they can design and deploy their own consumer engagement tools and applications</p> | <p>DOH</p> <p>NY eHealth Collaborative</p> <p>Payers</p> <p>Providers</p> <p>Community-based organizations</p> |

(continued)

Appendix Table 17A-1. Models and strategies proposed in New York’s Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|---|--|------------------------------|---|--|
| Value-based insurance design Support linkage of payment to cost and quality through rate review VBID, and multi-payer initiatives | Emerging area in New York; payers frequently incorporate VBID in pharmacy benefits and other select areas but no widespread/comprehensive VBID program | General population | Potential regulatory actions *Explore whether streamlined DFS policy form and rate review process or publication of successful results would increase the use of VBID Consider establishing a minimum definition of what constitutes “VBID” to help ensure the evolution of approaches Proposed executive branch actions Convene working group with DFS, DCS, Governor’s Office of Employee relations, union representatives, and other stakeholders *Consider launching opt-in VBID program for state employees by open enrollment 2015 State facilitation of system change *Payers to experiment with and increase offering of VBID plans | DOH DFS DCS Governor’s Office Unions Other payers Providers Community-based organizations |

¹Policy levers include Medicaid waivers; federal grants (including Round 2 SIM award); state laws; state regulations; state investments (e.g., in public health programming); foundation grants; employer-led coalitions to drive change among providers, purchasers, or plans; state government-led coalitions, task forces, or commissions to drive voluntary change among providers, purchasers, or plans; state purchasing contracts; and state-level (Governor-initiated) executive policy directives.

Abbreviations: ACA = Patient Protection and Affordable Care Act, ACO = accountable care organization, AHRQ = Agency for Healthcare Research and Quality, APC = Advanced Primary Care, APD = All Payer Database, CHIP = Children’s Health Insurance Program, CMS = Centers for Medicare & Medicaid Services, CPCi = Comprehensive Primary Care Initiative, DCS = Department of Civil Services, DFS = Department of Financial Services, DOH = Department of Health, DSRIP = Delivery System Reform Incentive Programs, EHR = electronic health record, FFS = fee for service, FIDA = Fully Integrated Duals Advantage, FQHC = Federally Qualified Health Center, HMO = health maintenance organization, LTC = long-term care, MRT = Medicaid Redesign Team, N/A = not applicable, NCOA = National Committee for Quality Assurance, NYS = New York State, 17-SHIP = state employees’ health insurance program, PCMH = patient-centered medical home, PPO = preferred provider organization, QHP = Qualified Health Plan, RHIC = Regional Health Improvement Collaborative, RHIO = regional health information organization, SHIN-NY = Statewide Health Information Network for New York, SUNY = State University of New York, VBID = value-based insurance design.

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18. Ohio

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Ohio's Governor's Office of Health Transformation (OHT) began development of the state's Health Care Innovation Plan (the Plan) by convening the state's existing health care transformation expertise in an extensive process to facilitate stakeholder input. The Plan development process took place in the context of health and human services alignment and modernization initiatives already undertaken by OHT, existing experience in the private sector with delivery system innovation, a complex and varied health care market, and a concurrent decision to expand Medicaid. OHT staff worked closely with major insurers, providers, other relevant state agencies, and health infrastructure organizations (such as health information exchange [HIE] organizations). The state engaged less extensively with other stakeholders such as purchasers and consumer advocates.

The Plan centers on two primary models—a multi-payer patient-centered medical home (PCMH) and retrospective episode-based payments for acute care—which will be supported by enhancements to health information technology (health IT) and the health care workforce. The state plans to require these models for its Medicaid and state employee benefits contractors, and expects five payers covering 80 percent of the commercial market to voluntarily follow suit. Ohio's planned timing is to implement the multi-payer PCMH model to all willing providers statewide within 5 years and to implement episode-based payments for 20 episodes within 3 years (and 50 episodes within 5 years) in Medicaid, state employees' plans, and the five private plans. These strategies are projected to move 80 to 90 percent of the state's population into some form of value-based care, and to use expected net savings as reinvestments in Plan implementation. Since submitting its final Plan, Ohio has worked to refine the PCMH model it would use and define the first five episodes.

18.1 Context for Health Care Innovation

Ohio's State Innovation Model (SIM) Initiative planning took place in the context of: (1) the cabinet-level OHT, which had already undertaken initiatives to modernize Medicaid and streamline health and human services; (2) previous substantial innovation in the state, especially in the areas of quality improvement, PCMH, and health IT, and including some experience with episode-based payments; (3) a complex health care market; and (4) a recent decision to expand Medicaid.

Governor John R. Kasich created the OHT in 2011 as a cabinet-level health policy agency with no day-to-day responsibilities for managing state government operations. Much of

its funding for initiatives comes from an innovation fund created from Ohio’s three consecutive Children’s Health Insurance Program Reauthorization bonuses. Its charge is to perform three primary tasks: “Modernize Medicaid,” “Streamline Health and Human Services,” and “Pay for Value” (OHT, 2013a). Major projects for the first task include significant revisions to the hospital reimbursement system (diagnosis-related groups) and the state’s federal dually eligible beneficiaries demonstration. Second task projects include restructuring Medicaid to become a standalone cabinet-level agency and implementing a new electronic claims and eligibility system. These first two tasks were initiated through the administration’s first budget in 2011 and continue today. Both were largely internal to the state, and according to stakeholders, their implementation strengthened connections across agencies. The third task, which state officials describe as much more geared to engaging external stakeholders than the first two, had not begun prior to the Model Design Initiative.

Prior to this Initiative, Ohio was home to substantial health care innovation. Several Ohio hospitals are nationally renowned for quality improvement and patient safety, and some participate in federal and private payer accountable care organization (ACO) initiatives. The Cincinnati-Dayton region is one of seven regions nationally piloting the federal Comprehensive Primary Care (CPC) Initiative, a PCMH program that includes private payers and Medicare and emphasizes care coordination through technology. The Ohio Department of Health spearheads the Ohio Patient-Centered Primary Care Collaborative (OPCPCC), a coalition of primary care providers, insurers, employers, consumer advocates, government officials, and public health professionals to coordinate statewide efforts to implement best practices to advance PCMH work (Ohio Department of Health, 2013). Some Ohio stakeholders also have existing experience with episode-based payment: seven Ohio providers participate in the federal Bundled Payment for Care Improvement Initiative; UnitedHealthcare has instituted an episode-type payment for cancer care; and the Cleveland Clinic had its own experience with bundled payments. Ohio also has a Beacon community in Cincinnati and, through two HIEs in the state, boasts a relatively advanced health IT infrastructure. In addition to these targeted activities, the previous administration convened meetings among stakeholders around comprehensive health system transformation—described as large meetings facilitated by the Health Policy Institute of Ohio—although these efforts did not culminate in a detailed plan.

Another key contextual factor is Ohio’s large and complex health care market. In the commercial market, Ohio has more than 60 active health plans across the state, none with more than a 30 percent market share (OHT, 2013d). The state has a high percentage of lives in self-insured plans through employers. Ohio’s Medicaid program includes both managed care and fee-for-service (FFS) elements. In addition to its large rural population, Ohio has seven major metropolitan regions, several of which are home to nationally renowned health care providers (such as the Cleveland Clinic and Cincinnati Children’s Hospital).

Finally, Governor Kasich is widely seen as a strong leader who has shown a particular interest in health policy. In February 2013, he endorsed expanding Medicaid eligibility to Ohioans below 138 percent of the Federal Poverty Level (Palmer, 2013). In October 2013, 1 week before he presented the draft Plan to the Advisory Council of stakeholder CEOs, the Governor finalized his expansion decision—which became subject to a legal challenge by a group of state legislators on the grounds that he had bypassed the state legislature. In December 2013, the Ohio State Supreme Court voted to uphold the expansion decision (Navera, 2013). Stakeholders noted that the expansion decision strained the Governor’s relationship with the legislature, but was seen as positive in his relationships with hospitals, consumer groups, and health plans.

18.2 Planning Infrastructure and Process

An executive leadership team, consisting of the directors of OHT, Medicaid, and the Department of Health (all three of whom are cabinet members), led the Model Design work with strong support from the Governor. OHT staffed an extensive stakeholder process, with its director holding the bulk of the leadership responsibility and McKinsey & Company as consultants. The process involved multiple group meetings per week, along with many one-on-one meetings. Groups staffed by OHT included: (1) an Advisory Council of CEO-level stakeholders, which met infrequently to review the general outline of the Plan; (2) a Core Team of payers and state agency representatives, which held some decision-making responsibility; and (3) two Working Teams of various stakeholders, which met regularly to make recommendations to the Core Team on the elements of the Plan.

Stakeholders perceived the outline of the Plan (episode-based payment and PCMH, supported by technological and workforce infrastructure) as already formed by the time the stakeholder process began. However, those who participated were generally pleased—as one payer put it: “The state has done a very nice job of understanding the dynamics of this initiative.” Participants in the state’s Working Teams, including physician, hospital, health plan, and health infrastructure representatives, felt they had good input into the design of the Plan’s elements within the framework the state set out. In contrast to previous efforts in the state, the Governor intentionally kept the work groups small; as one state official said: “The Governor has been very comfortable saying to folks, ‘you know what, we’re going to have 12 people in this group, not 80.’ And that’s been important to be able to keep moving forward.” This meant some groups, notably consumers and some provider associations, felt excluded from the stakeholder process, although they generally support the framework of the Plan.

Governance and management. Ohio’s process was governed by the SIM Initiative executive leadership team, consisting of the directors of OHT, Medicaid, and the Department of Health, as noted. The OHT director was the overall leader of the process and, as such,

maintained a direct connection with the Governor. while the directors of the Ohio Department of Health and the Ohio Department of Medicaid oversaw specific work on PCMH and episode-based payment, respectively.

OHT staffed the initiative by communicating one on one with various stakeholders; staffing the Advisory Council, Core Team, and work groups; and providing dedicated staff to organize and facilitate all stakeholder engagement. McKinsey assisted with these activities. Ohio received a \$3 million Model Design award and added \$2 million from OHT's Innovation Fund. Because OHT already had discretion over the use of the fund, the state legislature did not have to approve this expenditure. Federal and state funds were used to hire McKinsey as consultants and support state staff.

Advisory council. The Governor's Advisory Council on Health Care Payment Innovation is a large group of CEO-level representatives of physicians, hospitals, insurance companies, businesses, and consumer groups (OHT, 2013c). The Governor convened the Council prior to the award (but after the application had been submitted), in some cases personally inviting representatives. Other representatives were invited by existing organizations that work with business executives, and likely through other means as well, although stakeholders did not elaborate on this. The Governor himself met with the group twice, first in January 2013 before the award, and again in October to lay out the draft plan. According to several stakeholders, participation in this group helped impart to key leaders the importance of health system transformation as a priority for the Governor, but did not provide an opportunity for input into Plan design. OHT sent initial requests to Advisory Council members for participant recommendations for the PCMH and episode Working Teams. OHT also took recommendations from stakeholders when inviting new people to the Working Teams; others who heard about the work were able to request to join as well.

Core Team. The Core Team was composed of five payers making up 80 percent of the commercial market in Ohio (Aetna, Anthem, CareSource, Medical Mutual, and UnitedHealthcare), Ohio Medicaid, the Ohio Department of Administrative Services, and the Ohio Bureau of Workers' Compensation (OHT, 2013d). Some of these payers had multiple representatives, for example if they had both a Medicaid and a commercial product. The Core Team met every other week to organize the overarching framework for the Plan (OHT, 2013b). The Core Team was described by some stakeholders as having decision-making authority, implying that the recommendations of the Working Teams were vetted by the Core Team. A key task for the group was sorting out which PCMH and episode elements would be standardized across payers, which would be aligned in principle but allow for differences across payers, and which would differ by design. To achieve buy-in, after each meeting McKinsey followed up with each of the Core Team payers to make sure they were on board with the process and the strategies being considered. McKinsey also used these conversations to solicit reservations or

confidential information payers might not want to share publicly with their competitors or the state. Payer stakeholders noted that they appreciated this aspect of the planning process.

State official and payer stakeholders strongly praised the Core Team's work, although some stakeholders outside this group noted feeling excluded. As one provider said: "The one part that was always sort of mysterious...when we had our large planning sessions it involved all the stakeholders: the provider community, the business community, the patient community, the insurer community. But then there were also references made to additional meetings that were going on directly with the payer community.... There was never really a good understanding for those who weren't in the insurance community of what was transpiring in those."

Working Teams. The two Working Teams (the PCMH Working Team and Episode Working Team)—composed mostly of payers, physicians, hospitals, health infrastructure organizations, and state staff—fleshed out the details of the PCMH and episode aspects of the Plan, respectively. The Medicaid director led the Episode Working Team, while the Health Department director led the PCMH Working Team, building off his existing role leading the state's OPCPCC medical home collaborative. After initially holding weekly hour-long meetings, the Working Teams met biweekly for 2 hours on alternating weeks, so stakeholders with an interest in both could attend both meetings (OHT, 2013b). Participating stakeholders were quite positive: (1) about the private sector expertise the state gathered, and (2) that the input from these Working Teams was incorporated into the Plan details. For instance, PCMH Working Team participants reported that the idea to model PCMH work after the existing CPC Initiative experience grew out of that Working Team. Participants remarked that the state provided very good communication at these meetings. OHT also organized one-time meetings on topics such as health IT.

Consumer engagement and other stakeholders. Interviewees had mixed views on consumer involvement in the process. Some payer and health infrastructure stakeholders said that consumers were well represented, especially on the Advisory Council and in OPCPCC, which had some overlap with the PCMH Working Team. One state official noted that consumer engagement was not a primary focus for the planning stage, because pursuing approaches for consumer buy-in would be the next step after completing the Plan. All consumer advocates felt that their engagement was weak, at best, and that their input would have added an additional perspective to the Plan. Advisory Council members were given 1 week to review the draft Plan and submit comments. Although Working Team and Core Team members had reviewed several iterations of the Plan already, consumer advocates had not seen it before. As one consumer stakeholder put it: "We didn't know we'd be asked to give feedback, and then we were asked to give feedback at the last minute." A few stakeholders also noted that labor representatives were missing from the process, and one payer said that large employers should have been included more.

18.3 The Ohio Plan

The Plan proposes two core strategies—PCMH and episode-based payments—that would be supported by improvements to health IT and workforce development. Under the Plan, Medicaid and the state employee health plan would adopt these strategies in their contracts, and private payers have voluntarily agreed to do the same. Stakeholders noted that other models such as ACOs were briefly raised, but the discussion mostly focused on operationalizing the episode and PCMH strategies already identified. *Appendix Table 18A-1* summarizes the innovations proposed in each category, initiatives on which they are built, populations they address, and the supporting levers and entities.

18.3.1 Models and Strategies

PCMH model. The Plan proposes a multi-payer PCMH program that would be implemented for all willing providers over 5 years. The model would include three payment streams, aspects of which would either be aligned or standardized, or would differ across payers: (1) support for practice transformation for less advanced practices; (2) compensation for nonclinical activities (e.g., care coordination); and (3) rewards for performance through shared savings, bonus payments, or capitation (OHT, 2013d). The model builds on existing work in the CPC Initiative, where payers and providers in Cincinnati-Dayton have already come together to develop a multi-payer PCMH model. Ohio would implement the multi-payer PCMH statewide in three waves. The first wave, refining and gathering lessons from the CPC Initiative pilot, has already begun. Wave two, expanding to all willing providers in a second metropolitan market, and the remaining providers in Cincinnati-Dayton, is planned to begin mid-year in 2014. The third wave, projected to begin in mid-year 2015, would complete the rollout to all Ohio markets, including rural markets, once they meet readiness criteria.

Episode-based payment. Ohio’s episode-based payment strategy is modeled after Arkansas’ design, with a retroactive payment made to a single provider identified as the “quarterback” or Principal Accountable Provider. By holding a single provider or entity accountable for care across all services in a specific episode definition, the model is intended to encourage high-quality, patient-centered, cost-effective care. Taking into account Ohio’s competitive insurance market and mix of FFS and managed care in Medicaid (as opposed to Arkansas’ pure FFS Medicaid and insurance market dominated by one payer) the Episode Working Team made design decisions around four core episode components: (1) accountability of the provider(s); (2) payment model mechanics, including whether it is retro- or prospective and the type of gain/risk sharing; (3) performance management; and (4) payment model timing and thresholds. The first five episodes Ohio will design are perinatal, acute asthma exacerbation, chronic obstructive pulmonary disease exacerbation, joint replacement, and percutaneous coronary intervention. Although some stakeholders had previous experience with episode-based payments, and this experience informed the planning process, the strategy in the Plan does not

explicitly expand on these initiatives. As noted, Ohio proposes implementing 20 or more episodes within 3 years and 50 episodes in 5 years (OHT, 2013d).

Health IT and enhanced data analysis. The Plan provides some explanation of the health IT elements that will support both PCMH and episode payment. The final Plan describes the need for analytics and reporting for claims data; the need for a provider portal for reporting clinical data for data exchange and aggregate performance analysis; and a plan to build on the state’s new health and human services data system for information on Medicaid claims, provider attribution, and potentially other uses (OHT, 2013d). Both state official and health system infrastructure stakeholders said that more complex plans were under discussion, such as defining a strategy for HIE statewide, and building on meaningful use requirements to incentivize and standardize clinical data reporting to enhance the state’s ability to measure performance with clinical and claims data. The lack of such details in the Plan is likely because, as several stakeholders noted, the state recognized the extent of the need and opportunity to build on its existing health IT late in the process, when the Plan was mostly written.

Workforce development. The Plan also describes building on its existing work to train the workforce necessary to successfully manage the system put in place by PCMH and the episodes. Ohio would tailor training through existing PCMH educational pilots and increase education opportunities by expanding mentorship programs and community-based residency opportunities for medical students. Under the Plan, Ohio would also expand: (1) scholarship programs for physicians and nurses to aim at retaining medical students to practice in the state, and (2) loan repayment programs to increase the supply of primary care providers (including physician assistants, nurse practitioners, certified nurse midwives, psychiatric nurse specialists, health service psychologists, licensed professional counselors, licensed clinical social workers, marriage and family therapists, registered dental hygienists, pharmacists, and community health workers)—especially those who work in advanced primary care practices or come from minority populations. Finally, the Plan proposes to enhance its data collection system to enable better forecasts of advanced primary care workforce needs (OHT, 2013d).

18.3.2 Policy Levers

Existing and proposed policy levers for Plan implementation are listed in [Appendix Table 18A-1](#). Ohio’s primary policy levers for both the PCMH and episode-based payment models are state executive branch action, state-facilitated system change, and to some extent private sector voluntary action. The state would require that Medicaid managed care plans and state employee plans pay providers according to the new models. The state expects the five commercial payers on the Core Team to voluntarily follow suit. As one state official put it, the executive branch action is intended to give commercial payers “leadership and cover” as they negotiate contracts in the new model with providers. The alignment across the state and adoption by five payers is an additional incentive for providers to accept the new models. The

goal is to “tip the scales” to where such a significant percentage of providers’ patient populations are covered by the same payment and reporting model that, for the sake of consistency, providers will ask other payers to follow. One provider group estimated this tipping point would be at 50 to 60 percent of a provider’s business. Finally, although large employers have been somewhat engaged in the planning process, the state expects the initial efforts to demonstrate value improvement within the state employee, Medicaid, and commercial markets. The state hopes this evidence, along with a strategy to actively engage groups such as chambers of commerce, will drive large employers to adopt these models in the self-insured market.

The strategy of using Medicaid and state employees innovations to drive changes in the broader market is new for Ohio. The general sentiment from interviewees is that previous innovations in these programs have been of a lesser scale, described by some as “tinkering.” In addition, by some accounts this is the first time the state has seriously reached out to the private sector to develop a statewide strategy. Several state officials described previous work through the OHT as laying the groundwork for this new, more far-reaching strategy.

Other policy levers Ohio proposes for its health IT and workforce strategies include Medicaid investment to incentivize changes and state regulatory action. For health IT, Ohio would continue offering Medicaid electronic health record (EHR) incentive payments to eligible practices. The state also plans to discuss other policy levers to enable HIE for health care providers not eligible for the Medicare or Medicaid EHR Incentive Program. An additional policy lever for health IT adoption is voluntary reporting and analysis by providers and payers as part of performance reporting—including episode-based payment and PCMH—with health IT adoption and use characterized in the Plan as “a practical requirement” for value-based purchasing.

To achieve its workforce development goals, Ohio proposes to enable changes through regulation and financial investment. The state’s regulations would be revised to define core competencies for health professions such that all professionals would require additional training relevant to new payment models. In addition, Medicaid would allocate Direct Medical Education payments to support training in comprehensive primary care, primary care placements in recognized PCMHs, and residencies in community practices. The state’s licensure boards would provide matching funds to the State Loan Repayment Program to support loan repayment to other nonphysician primary care providers. The Plan also proposes state investment in training (for example, a state-funded pilot program for PCMHs), scholarships, and revisions to the Physicians and Dentist Loan Repayment Programs. A recent Executive Order (2013-05K) already streamlines the process to facilitate licensure of veterans as advanced practice registered nurses and physicians’ assistants.

The state did not consider other policy levers that would have required changes in legislative authority. Some stakeholders alluded to the Governor’s strained relationship with the

legislature over Medicaid expansion, and the upcoming gubernatorial election, as reasons to avoid legislative policy levers and keep the payment innovation work as apolitical as possible. As one state official put it: “As much as we can do on our own, we want to.” Aside from legislative policy levers, two consumer groups said the state was not receptive to their suggestion of using transparency and public reporting as a policy lever.

18.3.3 Intended Impact of the Plan

In the final Plan, Ohio predicts that PCMH and episode payment together would reach 80 to 90 percent of the state’s population within 5 years. Elsewhere in the final Plan, Ohio states 5-year goals of encompassing 50 percent of all health care spending in episodes, and ensuring access to a medical home for 80 to 90 percent of the population. The five Core Team insurance carriers that make up 80 percent of Ohio’s commercial market are expected to launch both models over the next 3 to 5 years, with Medicaid and state employees each also implementing both models. Notably, 66 percent of Ohio lives are in self-insured plans, meaning these may be excluded from the initial implementation (OHT, 2013d). Some interviewees remarked that these goals seem “ambitious.”

Episode-based payments are a new initiative in Ohio, whereas PCMH scales up the existing work of the CPC Initiative, which involves many of the same payers although it is only in Cincinnati-Dayton. At least one consumer group said health disparities were not considered enough during Plan development. State officials and payer and provider stakeholders said that populations with special needs were taken into account during Plan development, although this was not elaborated.

18.3.4 Proposed Next Steps

Ohio will continue to work through OHT’s stakeholder engagement infrastructure to implement the Plan. As of December 2013, the Episode Working Team had transitioned to heavier clinical focus to work on the design of specific episodes, with the goal of completing the first five episode designs before applying for Round 2 funding. According to the state team, its next big focus is to be provider engagement through involvement in the Working Teams and a broader education effort. The purpose of this engagement is both to ensure the episodes are technically feasible and to strengthen provider support for the Plan; state officials viewed this support as crucial to the continued success of the Plan. The state has also begun discussing the model with the third-party administrators for state employees and is making preparations for an educational campaign for state employees around the benefits of PCMH. The funding sources laid out in the Plan to support the new models include payments from payers to providers that come, in part, from reinvested savings. The Plan anticipates a “relatively neutral balance between savings and investment” after the startup phase.

18.4 Discussion

Ohio has an active provider and payer community already engaged in many innovative delivery and payment models. The Plan would align work these groups have undertaken while expanding it to other providers and payers. Through the planning process, Ohio brought together many groups already testing innovative strategies to discuss how to coordinate and determine how a statewide model would look. The majority of the stakeholders, both inside and outside the state, expressed optimism that these models could be implemented successfully. Still, concerns persist—such as whether stakeholder buy-in will continue once the process moves from conceptual framework to details, and whether the state’s technological infrastructure is ready to support ambitious value-based purchasing.

18.4.1 Critical Factors Shaping the Plan

Critical factors in shaping Ohio’s Plan, according to stakeholders, included previous experience among many stakeholders with innovative delivery and payment models and a stakeholder engagement process led by the Governor that allowed the state to build buy-in and take advantage of existing expertise to inform the Plan.

Although Ohio had not previously undertaken a statewide health transformation initiative, many regional and private sector efforts already existed. These experiences informed the Plan directly, especially on the PCMH side, which builds on the CPC Initiative. In addition, existing efforts informed what Ohio did *not* include in the Plan. With the ultimate goal of moving the whole state to accountable care, Ohio sought to accommodate the wide range of plan and provider experience with innovation in Ohio. For health systems with less experience, rather than push them all the way to ACOs immediately, PCMH and episode payment are intended to be “the building blocks to increase capacity” for functions like performance measurement, quality improvement, and global budgeting—which the state knew would be needed in a full ACO. At the same time, for providers already on the cutting edge, PCMH and episodes could be incorporated with minimal disruption to their existing accountable care arrangements. Notably, a chief outcome state officials sought to *avoid* was becoming a “referee” among particularly innovative plans and providers vying to be the only ACO for a region. Instead, the state’s desired outcome was identifying areas where plans and providers could align or standardize.

In addition to the efforts already existing, a second critical factor was the stakeholder engagement process that created buy-in and an informed Plan. Although the Core Team and Working Teams were time consuming activities, participants found them worthwhile because their input was heard. Proof of this input was in the state’s decision partway through the process to embrace the CPC Initiative as the basis for the multi-payer PCMH and in state officials’ increased awareness around health IT needs. The align-standardize-differ framework made payers feel comfortable enough to participate and commit to some alignment. As even a

skeptical consumer advocate remarked: “If you don’t have payers willing to start paying for value, you can’t do this. Getting those payers as players to the table is a triumph.” One state official noted that almost everyone the state approached for participation joined enthusiastically, and that as word spread of the work that was happening, others were eager to join. Almost all stakeholders credited the Governor’s leadership with driving the process, and believed he shared their overarching objectives: jobs, improved quality, and reduced cost. As one payer said: “There is a level of support that transcends politics. We have a Governor who is at the table; he’s a strong proponent for the right reasons...quality results, the PMPM [per member/per month] costs for health care, the workforce development.”

18.4.2 Lessons Learned

Ohio’s experience in the SIM Model Design Initiative yields several lessons, according to stakeholders:

- **The Governor’s involvement provided strong leadership and helped secure buy-in.** The Governor’s strong support of the initiative, including his meetings with the Advisory Council, helped stakeholders see the Plan as a reality and as important enough that they should participate. For example, one state official described a meeting between the Governor and five Core Team payers: “He went person by person and he said ‘are you with us through the end of this process, yes or no?’” The leadership helped secure buy-in for the state’s vision—as one provider representative said: “I feel relatively convinced that this is where we’re headed”; and multiple stakeholders described the Governor’s approach as “progressive.” Notably, the Governor and OHT carried out the Plan process simultaneously with the Medicaid expansion, keeping transformation relatively apolitical even though it was closely related to expansion.
- **Having a dedicated staff at OHT (plus McKinsey) was crucial for maintaining a high amount of communication and navigating many facets of a comprehensive strategy.** By locating the initiative at OHT, with a team of staff dedicated to the transformation effort rather than daily operational responsibilities like most state staff, Ohio held an extremely high number of meetings and individual conversations. This allowed stakeholders to get into a good working rhythm and maintain momentum. Furthermore, with OHT’s dedicated staff, the state has been able to more easily work in many directions on a comprehensive strategy, rather than zero in on only one issue. Several stakeholders attributed their satisfaction with the process to OHT’s work.
- **External consultants were a valuable supplement to state staff, helping overcome limitations in the state’s role as a convener.** Several stakeholders noted that McKinsey’s involvement was quite valuable. As a neutral party, McKinsey was able to follow up one on one with stakeholders to understand their perspectives on the Plan that they may not have wanted to share with the state or with other stakeholders. The particular McKinsey team involved was based in Ohio, and had previously worked

with many of the stakeholders, giving them an advantage as trusted listeners. In addition, McKinsey's staff had technical expertise, allowing them to work with individual hospitals and payers to better understand their technological capabilities to ensure the Plan was feasible. As part of a national organization, McKinsey staff was also able to help the state's insurance affiliates educate leaders at their national offices to secure commitments to move forward with the process in Ohio.

- **Involving multiple payers gave Ohio's process momentum.** Given Ohio's competitive insurance market, payers have not historically worked toward common goals together, with the notable exception of the CPC Initiative. When OHT brought them together in the Core Team, commercial payers said they were surprised by one another's willingness to align. A one payer stakeholder said: "I've been amazed at the level of information sharing and people candidly sharing concerns. There are conversations I never would have been a part of with my colleagues." In addition, payers appreciated that Medicaid participated as a fellow payer stakeholder, rather than directing the process. Seeing other payers and Medicaid begin to embrace the principles of the Plan helped payer representatives sell the Plan to their own companies, creating more buy-in and motivation all around.

18.4.3 Potential for Implementation

Ohio's inclusive process created broad support among plans and providers for the overarching framework of PCMH, episode payment, and infrastructure investments. Several stakeholders, both in and outside state government, noted the strong governance structure and state leadership as key success factors for Ohio's Model Design process. As one payer said: "I think it's one of the best-implemented Working Teams, best led and best designed... Sometimes you can't do everything for all parties, and then they explain why they can't." Stakeholders also expressed confidence in OHT's ability to implement the Plan. As one person said: "I don't think they've bitten off more than they can chew." Even though they were not engaged extensively, multiple consumer groups also echoed the sentiment of support for the general direction of the Plan. As one consumer stakeholder put it: "I think the Plan is a good starting point but there are important details that need to be filled in."

Not surprisingly, given that the process focused on the overarching framework, many stakeholders expressed concern about the underlying details of implementation. As meetings moved from concept planning to episode design in November and December, issues surfaced—such as the need to implement new technology for measuring and reporting performance, the structure of HIE in the state, and unrealized opportunities to use data infrastructure beyond claims data. These concerns about the technological infrastructure—which likely reflected Ohio stakeholders' existing awareness of health IT issues due to the state's relatively advanced infrastructure—were echoed across all stakeholder types (state officials, providers, plans, health infrastructure organizations, and consumers). One stakeholder attributed the earlier lack of attention to the opportunity to build on health IT to McKinsey's lack of awareness of these

opportunities because Arkansas, which was McKinsey's basis of experience, does not have as highly developed a health IT infrastructure to build from as Ohio'. At the same time, when these issues emerged later in the process, the state responded by putting a strong effort into further developing the health IT strategy to support the Plan. As explained in the health IT section above, although these elements were not all included in the final plan due to timing, both state and other stakeholders described complex plans under discussion to strengthen the state's health IT infrastructure.

Still, both the state and other stakeholders generally expect implementation to be successful, although the numerical goals (including the spread of PCMH and number of episodes) seem ambitious to several. Stakeholders were confident of PCMH implementation, but less assured episode payment would go forward without (or even with) a Round 2 award, at least at the pace anticipated in the Plan. This is largely because PCMH builds on existing work, whereas the episodes are new and technically complicated. One provider association gave the episodes a "50-50" chance of implementation. Consumer representatives noted the state has significant work in building consumer awareness and support for the Plan; interviews with both state officials and consumer representatives gave some indication that the state is receptive to increased consumer engagement.

Ohio's biggest risk is said to be losing hospital and physician support (and to some extent, insurance carrier support) as the process moves from general concepts to the details of payment methodology and performance reporting. Providers already expressed some wariness about these details. For example, one hospital representative had concerns that commercial insurance rates would be lowered if they were even informally tied to Medicaid rates. One provider group mentioned that it will likely hire consultants to advocate with the state during the episode development process; this was a step the group had taken before on previous technical Medicaid initiatives. In a state with a largely managed care environment, hospital and health system support is especially crucial for implementation, because even if payers are on board, they must negotiate separate contracts with every hospital and health system. Another noted risk is that Ohio's strategy will be impractical to implement without the proper data flow infrastructure for performance measurement and payment. Stakeholders and the state strongly recognize this risk, however, and in recent months have turned toward addressing it. Yet another risk is said to be the need to engage large employers. With a high percentage of lives in self-insured plans, employers will be essential in reaching 80 percent of the state's population and for engaging providers. One stakeholder described it as a "who's first mentality" among employers hesitant to demand innovations from their plan administrators. The state has left employer engagement (and consumer engagement) to a second phase of the Plan. The ability of the state to draw in large employers and consumers in a later phase would be a major test of Ohio's explicit strategy of limiting the number of stakeholders in initial discussions to make the process manageable.

Although Ohio chose to emulate Arkansas' strategies of PCMH and episode payment, the Plan is innovative in several key ways. The governance structure has thus far been highly effective for working through the complexities of a multifaceted approach, with the bulk of the work conducted through a dedicated team at OHT, along with intensive roles for fellow cabinet-level leaders in the Departments of Medicaid and Health. Unique in Ohio is the plan to build on its CPC Initiative work (which was also a Beacon community and a Regional Health Improvement Collaborative), thus capturing years of lessons learned and alignment with the federal government. Finally, unlike Arkansas, Ohio explicitly views PCMH and episode payment as stepping stones to a future accountable care strategy. None of these innovations seems to increase the risk for Ohio's implementation. In fact, by building on past experiences in Ohio and elsewhere, the strategy likely increases the Plan's chances of implementation.

18.4.4 Applicability to Other States

In some ways, Ohio is more complex than many other states, according to stakeholders. Its Medicaid program is split across managed care and FFS, its insurance market is highly competitive, it has several already innovative providers, there are many major metropolitan areas and a large rural population, and the state is home to many large self-insured employers. Although these complexities pose challenges to Ohio in developing an aligned, comprehensive strategy, they do not mean Ohio's work is not applicable in other states, according to stakeholders. On the contrary, Ohio's lessons should be valuable to other states with less complex markets, as well as to similarly complicated states. For example, the strong leadership and governance structure, which have helped Ohio bring together a broad array of stakeholders to find common ground, hold lessons for many states. In addition, Ohio is one of the few states with a CPC Initiative, and its Plan is uniquely aligned with that federal initiative, for example through the technological infrastructure and payment standards for PCMH—making it an important demonstration for other states that strive to be in alignment with future federal policies on health IT and Medicare payment.

18.4.5 Limitations of This Evaluation

The hospital and health system perspective may not be fully represented in this analysis. A few stakeholders noted that large hospitals and health systems were more actively engaged in the process than their associations. However, because of a lack of response and scheduling difficulties, only provider association representatives were interviewed. All interviews took place after the Plan was fully drafted and either out for review or submitted.

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Appendix Table 18A-1. Models and strategies proposed in Ohio Health Care Innovation Plan

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|--|--|--|---|--|
| <p>PCMH model</p> <p>Largely modeled after the CPC Initiative, enabled by technology, and integrating community health</p> <p>PCMH model to be rolled out to all willing providers statewide within 5 years</p> <p>Model will include three payment streams: (1) support for practice transformation for less advanced practices; (2) compensation for nonclinical activities (e.g., care coordination); and (3) rewards for performance through shared savings, bonus payments, or capitation</p> <p>Depending on the element, components of the PCMH model will be standardized, aligned, or differ across payers</p> | <p>The new model most strongly builds off the CPC Initiative in southwestern Ohio; it will also rely heavily on the existing multi-stakeholder PCMH planning and implementation infrastructure of the OPCPC</p> <p>Although not directly based on these models, other stakeholders in Ohio have PCMH experience through 48 PCMH education pilot sites; multi-stakeholder regional health improvement collaboratives in Cincinnati, Columbus, and Cleveland; and private PCMH pilots and NCQA accredited practices operating within the state</p> | <p>Medicaid, state employees, privately insured; Ohio’s goal is to have 80%–90% of the total population with access to a medical home within 5 years</p> | <p>Proposed executive branch action</p> <p>*Implement payment mode to PCMHs in Medicaid (both FFS and MCO) and state employees plans</p> <p>Potential executive branch action</p> <p>Submit necessary state plan amendments or Medicaid waiver applications</p> <p>Proposed state facilitated system change</p> <p>*Participation from payers (especially those that have a Medicaid MCO business) to implement PCMH in their non-Medicaid lines of business</p> <p>*Private sector participation of large employers and providers to further encourage adoption of PCMH in commercial and self-insured plans</p> <p>Proposed federal action</p> <p>Medicare adopts PCMH model, including payment to Ohio PCMHs</p> | |

(continued)

Appendix Table 18A-1. Models and strategies proposed in Ohio Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|---|---|--|---|--|
| <p>Episode-based payment</p> <p>Retrospective episodes with a principal accountable provider, beginning with 3-5 episodes and increasing to 20 episodes within 3 years</p> <p>Elements of episodes will be standard across payers (e.g., quality measures, principal accountable provider)</p> <p>Some elements will be aligned across payers (e.g., principles of risk sharing and timing)</p> <p>Remaining elements will differ across payers (e.g., payment amounts, risk adjustment)</p> | <p>The new model does not expand on previous initiatives, instead taking a new approach for Ohio; however, stakeholders have existing experience with episodes through the Federal Bundled Payment for Care Improvement Initiative (seven Ohio providers participate); Cleveland Clinic experience with bundled payments; and UnitedHealthcare’s episode-type payment for cancer care</p> | <p>Medicaid, state employees, privately insured, Ohio’s long-term goal is to have 50%–60% of health care spending in the state to be in episodes</p> | <p>Proposed executive branch action</p> <p>*Implement episodes in Medicaid (both FFS and MCO) and state employee plans</p> <p>Develop a common reporting format for all payers</p> <p>Potential executive branch action</p> <p>Submit necessary State Plan Amendments or Medicaid waiver applications</p> <p>Proposed state facilitated system change</p> <p>*Participation from payers to implement episodes in commercial plans</p> <p>*Private sector participation of large employers and providers to further encourage adoption of episodes in commercial and self-insured plans</p> | |

(continued)

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Appendix Table 18A-1. Models and strategies proposed in Ohio Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|--|--|-----------------------|--|--|
| <p>Health IT and enhanced data analysis</p> <p>Build on claims data in its new Enterprise Data Warehouse (making necessary modifications to the system)</p> <p>Develop a statewide HIE strategy built on two existing HIEs to supply clinical data to support both episodes and PCMH practice transformation</p> <p>Continue to develop ways to conduct analytics and reporting to support value-based payment, and ways to reach rural, small, and behavioral health providers</p> | <p>Two existing HIEs (HealthBridge and CliniSync) that together cover the whole state</p> <p>Enterprise Data Warehouse containing data from across the state health and human services program spectrum including Medicaid eligibility data, SNAP and TANF data, and Medicaid claims data from Ohio MMIS</p> <p>Existing experience with technology-enabled transformation through Beacon community and CPC Initiative</p> | <p>N/A</p> | <p>Proposed executive branch action</p> <p>Continue Meaningful Use EHR incentive payments to encourage technology adoption and promote their availability to eligible providers</p> <p>Hire vendor to design solution for analytic tools that could also be adopted by other payers</p> <p>Potential executive branch action</p> <p>Provide HIE connectivity to providers not eligible for Meaningful Use EHR incentive payments</p> | |

(continued)

Appendix Table 18A-1. Models and strategies proposed in Ohio Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|--|---|-----------------------|---|--|
| Workforce development | Office of Workforce Transformation | N/A | Existing | |
| Align loan and loan repayment policies with workforce priorities | Ohio Department of Health's Primary Care Workforce Plan | | Executive Order 2013-05K to streamline transfer of educational credits and licensure process for veterans who are advanced practice registered nurses or physicians' assistants | |
| Use the Department of Administrative Services e-licensure system to create a centralized data collection system with the national Minimum Data Set workforce forecasting model | Choose Ohio First scholarships for primary care | | Proposed state regulatory action Define core competencies for health professions that would require additional training to support new models of care Proposed executive branch action Allocate Medicaid Direct Medical Education payments to prioritize training in comprehensive primary care, primary care placements in recognized PCMHs, and residencies in community practices Expand medical and nursing scholarship programs Revise Physicians and Dentist Loan Repayment programs | |

¹Policy levers include Medicaid waivers; federal grants (including Round 2 SIM award); state laws; state regulations; state investments (e.g., in public health programming); foundation grants; employer-led coalitions to drive change among providers, purchasers, or plans; state government-led coalitions, task forces, or commissions to drive voluntary change among providers, purchasers, or plans; state purchasing contracts; and state-level (Governor-initiated) executive policy directives.

Abbreviations: CPC = Comprehensive Primary Care Initiative, EHR = electronic health record, FFS = fee for service, HIE = health information exchange, IT = information technology, MCO = managed care organization, MMIS = Medicaid Management Information System, N/A = not applicable, NCQA = National Committee for Quality Assurance, OPCPC = Ohio Patient-Centered Primary Care Collaborative, PCMH = patient-centered medical home, SNAP = Supplement Nutrition Assistance Program, TANF = Temporary Assistance for Needy Families.

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19. Pennsylvania

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Pennsylvania is a large and diverse commonwealth, with experience developing and testing health care system innovation models. Relatively new executive branch leaders, who were sensitive to Pennsylvania’s competitive insurance marketplace and stakeholders’ lingering hard feelings from the process used during earlier similar initiatives, led the State Innovation Model (SIM) Model Design process. The Health Care Innovation Plan (the Plan) development was led by the Secretary of Health and a core project team. Stakeholder involvement was widespread—with the Governor’s Office inviting more than 250 stakeholder organizations from all relevant sectors to participate in seven workshops, and a draft Plan circulated for public comment before being finalized.

The fundamental goal of the state’s Health Care Innovation Plan (the Plan) is to reform the organization and delivery of care for 80 percent of the state population, to be phased in over 5 years. This is to be accomplished primarily through patient care medical homes (PCMHs), accountable provider organizations (APOs), episodes of care (EOCs), and community-based care management (CM) teams. The Plan reflects Governor Tom Corbett’s support of leaving many decisions about the delivery system redesign in the hands of the private sector. The commonwealth sees its role as convening the innovation discussion; expanding needed infrastructure, such as health information exchange (HIE) capability and telehealth; training and expanding the workforce; and setting an example through delivery innovations for the populations for which it is a purchaser of care (Medicaid, Children’s Health Insurance Program [CHIP], and, for government employees and retirees, the Pennsylvania Employee Benefits Trust Fund [PEBTF]). State action is expected to foster voluntary private sector reform along parallel lines.

19.1 Context for Health Care Innovation

Challenges to planning and implementing health care system reform in Pennsylvania include the commonwealth’s diverse population and geography. The sixth-largest state, with more than 12.7 million residents, Pennsylvania is spread over an extensive landscape containing a mixture of dense and smaller urban and suburban areas and more remote rural townships (U.S. Census Bureau, 2010). The commonwealth’s largest metropolitan areas, Philadelphia in the east and Pittsburgh in the west, are home to more than 20 percent of the state’s population (U.S. Census Bureau, 2010). Urban counties support twice as many health professionals per 100,000 residents as rural counties, leaving one-fifth of the population living in either medically

underserved or health professional shortage areas (Health Resources and Services Administration, 2010).

Pennsylvania has the fourth-oldest population in the United States; 16 percent of the state's population is aged 65 and older (U.S. Census Bureau, 2010). Among adults 18 to 64 years, 29 percent are obese and 35 percent are in fair or poor health (The Commonwealth Fund, 2011). Compared to national averages, Pennsylvania adults have a higher prevalence of such chronic diseases as heart disease, cancer, and kidney disease (Centers for Disease Control and Prevention, 2012).

With regard to health care coverage, 15 percent of Pennsylvanians have Medicaid benefits, most (80 percent) through HealthChoices, a mandatory managed care program (Commonwealth of Pennsylvania, 2013). Medicaid coverage for physical and behavioral health benefits is provided under separate managed care plans. The commercial market provides private coverage to 55 percent of the population—with two payers, Highmark and Independence Blue Cross, accounting for nearly half of that market (Commonwealth of Pennsylvania, 2013). Medicare covers 16 percent of the population. The uninsured are 11 percent of the population and primarily live in rural regions (U.S. Census Bureau, 2010). The Healthy Pennsylvania program, released for public comment on the same day as the Plan, would expand Medicaid through commercial providers to adults with incomes up to 133 percent of the federal poverty level using a Medicaid section 1115 waiver; this would provide coverage to 500,000 individuals.

Most of the state's earlier health care delivery reform efforts were narrower in scope than the Model Design Initiative. Although stakeholders recognized the advantages of aligning health care reform statewide, they appreciated that earlier, smaller initiatives reflected the commonwealth's varied delivery system needs. Many of these initiatives also sought innovation in case management and transitions of care—including Health Quality Partners, Pittsburgh Regional Health Initiative, and Centers for Medicare & Medicaid Services (CMS)-funded Transitions of Care Initiatives (Commonwealth of Pennsylvania, 2013).

In 2008, the Pennsylvania Department of Health (DOH) launched the Chronic Care Initiative (CCI), a state-supported delivery system reform effort to aid practices in transforming towards the PCMH model. Medicare joined this initiative under the Medicare Advanced Primary Care Practice Demonstration on January 1, 2012. DOH estimates that more than 1.18 million patients have been served by providers demonstrating improved practice performance, quality, cost reduction, and patient experience (Commonwealth of Pennsylvania, 2013). The CCI was the building block for the Plan, laying groundwork for many of the proposed models based on lessons learned regarding unique aspects of the commonwealth's health care environment.

The development of the Plan was informed by data from the Pennsylvania Health Care Cost Containment Council (PHC4), an independent state agency established in 1986 to collect, analyze, and distribute health care information to providers and the public. PHC4 reports on a variety of health care quality topics such as hospital performance, potentially avoidable hospitalizations, and cardiac care. Plan development was also informed by data provided by commercial insurers, managed care plans, CMS, and others. Many stakeholders commented on the need for greater access to data and expanded opportunities for information exchange.

19.2 Planning Infrastructure and Process

Key components of the SIM planning process included commitment from the Governor's Office, leadership from DOH with cross-agency participation, consultants hired to help facilitate stakeholder engagement and provide technical expertise, and the infrastructure to support stakeholder engagement.

Executive leadership commitment. The Governor's Office and leadership from key state agencies supported the SIM Model Design Initiative. The Governor's Office assigned day-to-day oversight responsibility for developing the Plan to DOH, but signaled its commitment to the Initiative through periodic attendance at meetings and involvement in high-level decision making throughout the planning period. As needed, the Secretary of Health received guidance from an executive leadership team consisting of the Governor's Office, state agency leaders, and a policy advisory team consisting of policy advisors from key state agencies: the Departments of Public Welfare ([DPW], Pennsylvania's Medicaid agency), Insurance, Aging, and Drug and Alcohol Programs; the eHealth Partnership Authority; and PHC4.

Organizational structure. The Plan was developed under the leadership of the Secretary of Health and a core project team. The SIM Project Director led the core project team of a small number of DOH staff, senior managers from DPW, and several consultants. The Secretary of Health and core project team members from DOH and consultants constituted the project leadership team, which met as needed and communicated regularly to make decisions during the planning process. The Secretary of Health also met weekly with leaders from DOH bureaus to receive updates, provide guidance, and discuss access to agency resources that would assist the planning process.

Role of consultants. SIM leadership relied heavily on expert consultants who had worked on previous initiatives similar to the CCI—including Pennsylvania State University, other academic institutions, and Bailit Health Purchasing—and helped write the Model Design application. Following the award, these consultants organized and moderated stakeholder meetings and developed initial “straw-man” models that had evolved from earlier initiatives, which served as the catalyst and point of departure for stakeholder discussions. Finally, the consultants helped to incorporate stakeholder feedback and draft the Plan.

Stakeholder engagement. The Governor’s Office formally invited more than 250 stakeholder organizations to participate in seven work groups: Delivery Models, Information Technology Infrastructure Design, Payment Methodologies, Performance Measurement, Public Health Integration, Workforce Development, and Pediatrics. Stakeholders included consumers, foundations, insurers, managed care organizations (MCOs), professional associations, providers, public health entities, unions, quality assurance organizations, drug and alcohol treatment providers, aging and long-term care organizations, elected officials, community organizations, academia, and government agencies. Stakeholders were enthusiastic about being engaged in the planning process and acknowledged the diversity of viewpoints. One stakeholder explained: “We’re there because we need to be there. If we are not at the table, we’ll be on the table.”

Most stakeholders reported that no key groups were missing from the planning process and were impressed by the scope and range represented. However, one stakeholder thought attendance at meetings seemed to “fizzle out” over time—that often, a more senior representative attended an initial work group meeting but “designated someone lower on the food chain” to participate in subsequent meetings. Only one stakeholder identified groups that were missing, noting lack of vocal participation from the employer and consumer advocacy communities. Although pediatric providers were invited to participate from the beginning of the process, some stakeholders thought the planning lacked a pediatric focus. In response, the seventh work group—Pediatrics—was added after the process had begun.

Each of the original six work groups met three times between June and September 2013. Between work group meetings, stakeholders had access to information through a “Base Camp” Web site. Generally, stakeholders found this to be an extremely helpful resource.

A state agency representative and a private sector partner co-chaired each work group with assistance from a facilitator. The facilitator was a content expert with experience running large stakeholder meetings. An oversight board of additional content experts and state agency staff advised the co-chairs and facilitators between meetings.

Initially, stakeholders provided feedback on a straw-man model presented by the co-chairs. Some stakeholders appreciated the efficiencies created by being given parameters within which to conduct their work. Many considered the planning process as primarily to build consensus on an already-formulated plan rather than to formulate a new plan. Said one stakeholder: “I think about 90 percent of what was concluded was already somewhat predetermined.... The last few months had more to do with consensus building rather than building a product from scratch.”

In December 2013, a draft version of the Plan was presented to the public for review and comment. DOH finalized the Plan after receiving this feedback.

State resources committed to the planning process. Pennsylvania relied heavily on federal funding for Plan development. Although commonwealth funding was not allocated, stakeholders reported that the commonwealth demonstrated commitment to the process through the contribution of considerable work hours of its public employees—in some cases, even more time than an agency had originally intended.

19.3 The Pennsylvania Plan

The Plan proposes involvement of all payers—Medicaid MCOs (HealthChoices), CHIP, commercial plans including the PEBTF, and Medicare. The parameters of the implementation and its timeline are most specific for HealthChoices and PEBTF plans, over which the commonwealth has the greatest control. The commonwealth generally proposes to facilitate change rather than impose it, by providing opportunities for discussion and training, and improving infrastructure. The intended result is greater system integration and access to data for providers and patients. The Plan proposes to change the organization and delivery of care for 80 percent of Pennsylvanians. However, stakeholders observed that the goal is ambitious and there is much to be done to reach it in 5 years.

19.3.1 Models and Strategies

The Plan’s models and strategies include five primary components: (1) payment reform and delivery redesign, (2) health information technology (health IT) infrastructure development and enhanced data analysis, (3) workforce education and development, (4) strengthening public health programs, and (5) creation of new infrastructure to support delivery system transformation, the Transformation Support Center. We do not know of any strategies that were considered but rejected. *Appendix Table 19A-1* provides an overview of the proposed models and strategies, initiatives on which they are built, populations they address, and supporting policy levers and entities.

With regard to the first component, Pennsylvania proposes four interrelated design models and payment methodologies in support of delivery system transformation: (1) PCMHs; (2) APOs—a form of accountable care organization (ACO); (3) EOCs; (4) and community-based CM teams. Both PCMHs and APOs emphasize value-based care delivery, intensive care management services for the highest-risk patients, and sharing in any savings they generate. The Plan is intended to promote transformation opportunities across primary care and specialist providers, regardless of patients’ source of coverage, with risk sharing/gain sharing relationships with payers increasing over time. The commonwealth is committing to being a leader in moving towards value-based purchasing through its own purchasing requirements for HealthChoices, CHIP, and PEBTF plans.

PCMH model. The PCMH model is intended to support patient-centered care in smaller primary care practices and allow for upside shared savings opportunities to reward value-based care delivery, rather than service volume. In support of this goal, the model includes enhanced service coordination, care management for the highest-risk patients, and greater patient engagement. The Pennsylvania PCMH model builds on the earlier CCI but allows for greater innovation in the contractual relationships developed between providers and insurers. To participate as a PCMH, practices must obtain or be seeking PCMH recognition from a nationally recognized entity, such as the National Committee for Quality Assurance (NCQA) or Commission on the Accreditation of Rehabilitation Facilities (CARF). Behavioral health practices can become PCMHs, according to the Plan, if they are willing to assume responsibility for physical health, either directly or in partnership with other health care providers.

To meet the PCMH enrollment target of 80 percent of beneficiaries by Year 5, nearly 2,000 additional practices would require transformation to PCMH status. In support of this goal, the PEBTF would begin to require that a percentage of covered lives be enrolled in PCMHs (and APOs) beginning in 2014. The PCMH adoption targets increase over time: the target for Year 3 is 50 percent of commercial, HealthChoices, and CHIP members and 20 percent of Medicare beneficiaries, increasing to 80 percent of commercial, Medicaid, and CHIP members by Year 5. The shared savings targets are lower: 10 percent for commercial plans and Medicare and 40 percent for HealthChoices and CHIP.

APO model. APOs allow larger organized groups of providers that have developed NCQA- or CARF-accredited PCMHs to contract with a payer on a population-based payment basis and assume upside shared savings and downside risk “responsibility for the cost, health, and health care of a defined group of patients” (Commonwealth of Pennsylvania, 2013, p. 72). An APO differs from an accountable care organization (ACO) by envisioning more flexibility in design and execution than is offered by CMS for Medicare providers. Still, the Pennsylvania APO plan anticipates integration of Medicare and Medicaid dually eligible beneficiaries by Year 3. APOs would receive comparative provider performance data, be required to include a CM team, and create linkages with such local community-based health services as healthy lifestyle programs and social services that may be needed (i.e., housing, substance abuse, mental health, and aging related).

The covered lives adoption targets increase over time: the target is 15 percent of commercial, HealthChoices, and CHIP members by Year 3, increasing to 40 percent of members by Year 5; and 6 percent of Medicare beneficiaries by Year 3, increasing to 23 percent of beneficiaries by Year 5. The Plan also proposes targets for APO acceptance of upside and downside risk: 10 percent of commercial and Medicare coverage, 33 percent of HealthChoices, and 40 percent of CHIP in Year 3, increasing to 80 percent for all APOs by Year 5.

EOC model. EOCs are a payment methodology providing a fixed dollar amount for a set of professional and facility services over a fixed period of time. EOCs can be defined in relation to a specific procedure (such as hip replacement) or care for a chronic disease (such as asthma). EOCs are intended to increase incentives to provide greater coordination among providers during the episode. This is an optional supplemental program for private payers to implement with their APOs or other providers. Beginning in Year 3, DPW would like its HealthChoices MCOs to consider implementing EOC pilot programs with their APOs for treating asthma, congestive heart failure, perinatal services, coronary artery disease, and chronic obstructive pulmonary disease. The payment model could include upside-only or upside and downside risk. The Transformation Support Center would facilitate forums with providers on EOC best practices.

CM teams. CM teams are intended to augment the care management services provided by HealthChoices PCMHs and APOs for their patients with complex physical or behavioral health conditions and social service needs that exceed the support capacity available through the practice. With support from the Transformation Support Center, CM teams would be encouraged to use “recovery-oriented delivery modalities” (Commonwealth of Pennsylvania, 2013, p. 52) and engage local community and faith-based services. DPW would fund up to 50 HealthChoices CM teams, which would be operated within APOs and some large primary care practices, such as federally qualified health centers. The Plan anticipates that 65 percent of HealthChoices high-risk patients would have care plans by the end of Year 3. CM teams would be optional for CHIP and commercial practices.

Health IT and enhanced data analysis. Overall, advances related to health IT are designed to support the reporting of similar useful information across payers; ensure that the information is available to patients, providers, and payers; and expand telemedicine capacity and use throughout the commonwealth.

With regard to reporting, stakeholders agreed on the need for an aligned set of standardized performance measures for APO, PCMH, and CM teams’ providers, payers, and consumers. During Plan implementation, a state-facilitated, stakeholder-driven process would decide on a core measure set that would be expanded over a 3-year period and then updated regularly. PHC4 would provide the clinical quality and performance data it already collects in standardized reports to APOs and PCMHs, which would allow for comparisons across providers. Additional statutory authority would be needed to collect emergency department and other data for some payers. DPW would provide PHC4 with patient-specific Meaningful Use clinical quality measures from all Medicaid providers receiving electronic health record (EHR) incentive grants. Submission would first be voluntary and then phased in over a 3-year period. PHC4 would also develop PCMH- and APO-specific reports to help these providers with their utilization and cost management.

To make clinical information available, the eHealth Partnership Authority is developing the secure exchange of health information by connecting local HIEs across the commonwealth. This network would support the exchange of communication among providers and the reporting of clinical data to PHC4. APOs that wish to contract with Medicaid PCMHs would need to meet minimum standards for their EHR systems.

Telemedicine would be used to increase access to specialty care in rural and underserved areas and provide clinicians with education and training. The Pennsylvania Telemedicine Advisory Committee would review current availability, identify unmet needs, and oversee development of the telemedicine portion of the Plan. Considered as being in an early phase, Pennsylvania is building hub and spoke networks around the commonwealth and anticipates that state grant funding will be made available to support additionally needed spokes, including telepsychiatry, telepediatrics, teleburn, and telestroke.

Workforce development. To promote expansion of the primary care, behavioral health, and dental care workforce, particularly within underserved areas, the Plan proposes implementation of an enhanced loan repayment program. Incentives would be available to providers across a number of clinical disciplines who have received PCMH training, are working in underserved areas at safety net sites, or are working in sites affiliated with health care organizations that demonstrate care delivery transformation. In addition, PCMH training would be provided through the Transformation Support Center (see below). Medical school curriculum redesign would be used to train providers in evidence-based team-based delivery models. Also, DOH would develop supply and demand models to estimate how the implementation of PCMHs and APOs would affect physician workforce needs.

Public health strategies. A State Health Improvement Plan (SHIP) is now being developed by DOH, in cooperation with a stakeholder advisory committee. Based on assessments of community health needs and resources, the SHIP will create strategies to coordinate public health and health care delivery efforts to address statewide priority areas. Under the Plan, the SHIP would be implemented locally through the health improvement partnership program. Health literacy–related materials in libraries would be expanded through leadership from the Pennsylvania Forward Health Literacy Team (PA Forward). In addition, DOH would begin to use geographic information system (GIS) mapping for chronic disease surveillance.

Infrastructure to support delivery system transformation. The Transformation Support Center would be the “hub” of the transformation process, creating a statewide infrastructure to provide training, on-site technical assistance, linkages between practices and community resources, dissemination of best practices, and instruction in how to engage in practice transformation. Its five program areas include: (1) quality improvement, (2) evidence-based care redesign, (3) workforce development, (4) coordination across systems, and (5)

incentive alignment. Its initial priority would be assistance to networks and health systems, while also providing services to independent providers.

Administratively, the Transformation Support Center would consist of a Support Center at the state level, coordinating and directing the activities of 7 to 10 regional hubs, under the guidance of a multi-stakeholder advisory group. The primary role of the regional hubs is to be coaching and providing linkages at the local level. The commonwealth proposes to establish regional hubs through state purchasing contracts with interested organizations. Contracting for regional hub administration is intended to promote their insulation from political pressures and ability to receive additional sources of funding. In Year 1, the Support Center would be implemented and the request for proposals for the regional hubs issued.

19.3.2 Policy Levers

The majority of the payment methodology changes are proposed to be implemented through the voluntary action of payers and providers. The current administration sees its role as primarily offering appropriate incentives for transformation. Also, the administration wishes to avoid the animosity expressed by payers resulting from the prior administration's "strong arming" during the precursor CCI. This section describes key policy levers presented in the Plan the commonwealth plans to pursue; additional policy levers are described in [Appendix Table 19A-1](#).

Payment reform and delivery redesign. The commonwealth proposes to use its power as a purchaser, regulator, and convener to implement PCMH, APO, EOC, and CM models. Pennsylvania would implement PCMH and APO models through purchasing contract requirements with HealthChoices and CHIP MCOs, establish PCMH and APO beneficiary enrollment targets in its PEBTF purchasing contracts, and advance regulatory changes to remove barriers to the integration of behavioral and physical health care. The Insurance Department would meet regularly with commercial insurers to assist with difficulties they might encounter during implementation and determine if any policy changes or levers are needed. The key policy lever to support implementation of the EOC models are purchasing contracts with HealthChoices physical and behavioral health APOs. With regard to CM teams, the commonwealth proposes a state budget appropriation to DPW to fund 50 CM teams to assist HealthChoices APOs with their highest need patients.

Health IT and enhanced data analysis. A mix of policy levers is proposed to develop the health IT and enhanced data analysis aspects of the Plan. To support implementation of consistent performance measures, the commonwealth proposes to require HealthChoices providers receiving EHR incentive grants to report Meaningful Use clinical quality measures to PHC4. Reporting would initially be voluntary and phased in over a 3-year period. APOs that wish to contract with HealthChoices PCMHs would need to meet minimum EHR system

standards. In addition, Pennsylvania may propose legislation to reauthorize PHC4 to collect, analyze, and disseminate performance data, and to authorize the collection of emergency department and other data for some payers. Further, the commonwealth would continue to convene stakeholder discussions, promote collaborative decision making, and support voluntary alignment among providers and payers to develop consensus reports and core measures. The Insurance Department would determine if insurers need additional antitrust protection to implement the Plan.

To support telemedicine, the Governor's Office would advance regulatory changes that would allow greater sharing of clinical information and remove impediments to the integration of physical and behavioral health. The commonwealth proposes to use state, foundation grant, and Round 2 award funds to implement technology advances where they are not economical for private providers.

To support HIE adoption, the state plans to convene private payers and providers with the purpose of encouraging voluntary change.

Workforce development. To support workforce development, the commonwealth proposes budget appropriations for an enhanced loan repayment program, with incentives to providers across a number of clinical disciplines who meet criteria in support of care delivery transformation.

Public health strategies. The commonwealth proposes budget appropriations to develop the SHIP, coordinating public health and health care delivery through identifying statewide public health priorities, developing task forces to address them, and establishing a health improvement partnership program to disseminate best practices developed through the SHIP.

Infrastructure to support delivery system transformation. The Transformation Support Center at the state level would be funded through appropriation, while the regional hubs would be funded through requests for proposals with nongovernmental organizations.

19.3.3 Intended Impact of the Plan

Pennsylvania anticipates meeting its goal of reaching 80 percent of covered lives by Year 5 of implementation (nearly 10 million people). Many stakeholders characterized this goal as “exceptionally aggressive” and “incredibly difficult” given the scope of the proposed changes and the number of covered lives in the state. They predicted that it was probably infeasible for large states with millions of covered lives to reach 80 percent. Based on this, one stakeholder recommended that federal policy makers develop a sliding scale to account for the number of covered lives in states, instead of requiring a one percentage goal across states.

Some stakeholders felt that the discussion of the proposed Plan lacked sufficient detail and additional details would more clearly determine its impact: “I think with everything it’s always going to be the devil’s in the details.”

19.3.4 Proposed Next Steps

Overall responsibility for implementing the Plan would reside with the Pennsylvania Center for Practice Transformation and Innovation. Reporting to the Secretary of Health, the Center would receive input from a management team of leaders from the Governor’s Office and key state agencies, and be advised by a Steering Committee of private-sector SIM Design work group co-chairs. Also, a Provider Advisory Committee would report to the Steering Committee.

Stakeholders differed in their evaluation of the need for Round 2 funding. Some thought that it would be essential for implementing the Plan in a timely manner and that, without funding, the timeline for implementation would dramatically increase because the state budget is “not that good right now.” Others thought the Plan would be implemented regardless of SIM funding, because payers in the state are “already moving in that direction.” Still other stakeholders expressed the opposite perspective that the Plan will “fall flat on its face” without future funding.

19.4 Discussion

The SIM Model Design process occurred during a period of rapid change in the health care delivery system, including pressure for improving access and quality of care while containing costs. Stakeholder participation was high, based on our observation of stakeholder meetings, with participants engaged and the conversation lively. Most described the experience as positive.

19.4.1 Critical Factors Shaping the Plan

Several factors stand out, according to stakeholders, as influencing the decisions Pennsylvania made about the models, strategies, and policy levers included in the Plan.

Pre-SIM initiatives and expertise facilitated the development of the Plan. Because of recent efforts at health care reform in the commonwealth, the SIM Initiative did not start from scratch but was able to build from the earlier CCI and PA SPREAD, among others. Also, SIM leadership called on expert consultants who had experience in reform efforts in Pennsylvania and other states.

Strong leadership and responsiveness to stakeholders. The day-to-day Initiative was managed by staff with ongoing access to the Governor’s policy advisors, assuring stakeholders of the value and high visibility of the Initiative. Separate private meetings with groups of

insurers and the addition of a pediatrics work group after the process began helped ensure that stakeholders' views were being heard.

Political orientation towards small government. The SIM leadership considered appropriate roles for the commonwealth to be limited to convening a dialogue, improving infrastructure capabilities for data exchange (including EHRs), and providing training and support to enhance implementation at the local level. Commonwealth leadership anticipates that payers and providers are already moving in the direction of shared risk and considers it useful to assist in the process, set an example through its own contracting requirements, and not impose undue burdens on commercial payers and private providers.

19.4.2 Lessons Learned

Pennsylvania's experience in the SIM Model Design Initiative yields several lessons, according to stakeholders.

- **The large number of stakeholders, representing a diversity of concerns, presented both opportunities and challenges to the planning process.** The commonwealth successfully engaged many stakeholders through work groups. However, it was sometimes difficult for stakeholders to get their work group to address their specific concerns or to know what another work group was proposing or why. Nevertheless, stakeholders considered inclusivity to be critical to the planning process: "Involvement of stakeholders early and often—you can't go wrong. Be inclusive, think about who's at the table and should be included."
- **The Plan had to account for regional diversity.** The commonwealth includes both rural and urban environments, differing in sophistication and needs: "Pennsylvania is mainly rural but has significant urban areas as well so access and types of services vary greatly. The ability of providers and systems to make some of those changes will vary significantly." To be successful, strategies need to be tailored to account for the realities of local communities. Stakeholders considered commonwealth-wide reform as important yet impractical: "It's nice to build a statewide reform but it's going to have to be implemented regionally using care neighborhoods to make it work."
- **Draw on successful strategies in the state.** A major strength of the Plan is that it draws on earlier successful initiatives in Pennsylvania related to PCMHs, ACOs, and related care coordination models. The approach to developing the Plan was described by stakeholders as consensus building. Starting from the lessons learned during earlier initiatives created efficiencies by providing parameters in which to work. Some stakeholders would have preferred greater flexibility in developing strategies from the ground up, yet many acknowledged that the short timeline likely precluded such an approach.

- The short timeline had advantages and disadvantages.** Stakeholders felt that the timeline for the Model Design process was extremely aggressive, and was further shortened by initial delays as the administration weighed political considerations. Most stakeholders felt the planning process was extremely well organized, though some criticized the short timeline as meaning that scheduling occurred at the last minute and sometimes prevented participation: “A lot of this was done last minute: ‘Can you show up in Harrisburg Monday at 3 pm’; when you’re a practicing physician that is really tough.” Other stakeholders thought the short timeline negatively affected the opportunity for creativity: “There was not time to flush out some of the newer and more innovative things because they would take more time...than some of the more mature ideas.” Still others indicated that the short timeline created efficiencies by forcing everyone to work at a quick pace: “The very quick think it through, get it on paper, move it forward timeline makes it easier for the different interest groups to cooperate. And, it gives them less time to spend on lobbying for their specific desire.” **Buy-in from the executive branch is critical for successful implementation.** While requiring that all strategies be approved by the Governor’s Office ensured they had high-level buy-in, some stakeholders felt a downside was a slowing down of the planning process. Some stakeholders felt that the approval process lacked transparency: “They would say ‘We’re not going there,’ even though we would make a very compelling argument about why we would think that would be a great way to go... We knew things went up to the [Governor] and things came down, but we did not know how that happened.”

19.4.3 Potential for Implementation

Generally speaking, stakeholders are enthusiastic about the Plan and consider the present as ripe for health care reform: “One of the reasons now is the right time is because health care in general is changing with the ACA.” Yet, some stakeholders identified individual providers as feeling “completely disenfranchised and hopeless about the future” because they were uncertain the Plan would allow them to remain financially viable and practicing.

Pennsylvania has an upcoming gubernatorial election in November. Stakeholders reported that the incumbent’s reelection is uncertain and the election results may influence the potential for Plan implementation: “Nobody is willing to double down and say that it is an absolute guarantee that we will have the same governor. And, governors don’t necessarily like implementing other previous governors’ work.”

19.4.4 Applicability to Other States

Many stakeholders said Pennsylvania’s unique delivery system and various reform needs may not apply to other states. Other stakeholders thought that Pennsylvania’s diverse delivery system was generalizable to other states because “you can take lessons we learned and apply them to urban and rural states.” States facing similar challenges with respect to population size

and geographic distribution may find that the lessons Pennsylvania has learned throughout this Initiative are applicable to their state.

As one stakeholder described, Pennsylvania “has been historically resistant to change” with regard to health care system reform. However, stakeholders enthusiastically commented on the intrinsic value of the multiangled collaboration that was uniquely provided by this Initiative. By successfully convening providers, payers, and purchasers, the state leadership brought forth thought-provoking conversation and debate surrounding health care reform, which had not been previously achieved in Pennsylvania.

19.4.5 Limitations of This Evaluation

The case study draws on publicly available documents and stakeholder interviews. The commonwealth did not provide access to the agendas or minutes for board meetings or pediatric work group meetings, so the case study lacks these details. In addition, we conducted stakeholder interviews before the state submitted its final Plan, and as a result stakeholder comments reported here may not accurately reflect opinion of the final Plan.

Stakeholders said the state made them aware that they were competing for funding with other states: “They open the meetings with, ‘Now remember that this is a competition. We are competing for funding. It’s not a guarantee that every state will be funded. We have to do something that makes us special. We trust you to protect that for us.’” Given this, stakeholders may have been reluctant to be candid about the planning process because they did not want to risk jeopardizing future funding. In support of this notion, we noticed an atypical lack of complaining about the planning process. It is possible that stakeholders were consciously avoiding negative statements and “telling us what they thought we wanted to hear.”

19.5 References

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Appendix Table 19A-1. Models and strategies proposed in Pennsylvania Health Care Innovation Plan

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|------------------------|--|--|--|--|
| PCMH model | PA Chronic Care Initiative, commercial payer-initiated programs | Commercial, Medicaid, CHIP, Medicare | <p>Proposed executive branch actions</p> <ul style="list-style-type: none"> *State purchasing contract through HealthChoices MCOs for the provision of Medicaid and CHIP coverage *State purchasing contract through PEBTF requiring that a percentage of members be covered through PCMHs <p>Proposed state regulatory actions</p> <ul style="list-style-type: none"> *Regulations to remove barriers to the integration of behavioral and physical health care (to be determined) <p>State facilitation of system change</p> <ul style="list-style-type: none"> Payers implement contracts for PCMH model voluntarily Insurance Department assists in identifying additional policy levers on the basis of feedback from commercial insurers | DPW, DOH, Department of Insurance |
| APO model | Based on non-Medicare ACO-type initiatives currently in operation nationally, PA Chronic Care Initiative | Commercial (including PEBTF), Medicaid, CHIP | <p>Proposed executive branch actions</p> <ul style="list-style-type: none"> *State purchasing contract through HealthChoices MCOs for the provision of Medicaid and CHIP coverage *State purchasing contract through PEBTF requiring that a percentage of members be covered by APOs <p>Proposed state legislative action</p> <ul style="list-style-type: none"> *State budget appropriation to DPW for its HealthChoices APO-based CM teams in the first 2 years of the Plan | Transformation Support Center, DPW for Medicaid |

(continued)

Appendix Table 19A-1. Models and strategies proposed in Pennsylvania Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|---|---|---|---|--|
| EOC model | Unknown | Medicaid chronic disease populations (optional for commercial and CHIP) | <p>State facilitation of system change Payers implement contracts with APOs voluntarily Insurance Department assists in identifying additional policy levers on the basis of feedback from commercial insurers</p> <p>Proposed executive branch actions *State purchasing contract change for HealthChoices physical and behavioral health MCOs to implement EOC models with their APOs *State purchasing contract for organizations to establish Transformation Support Center hubs</p> <p>State facilitation of system change Payers implement EOC method voluntarily Insurance Department assists in identifying additional policy levers on the basis of feedback from commercial insurers</p> | DPW, HealthChoices providers |
| Community-based care management (CM) teams | Case management and care coordination experience of the existing community-based behavioral health system | High-risk Medicaid patients | <p>Proposed state legislative action *State budget appropriation to DPW to fund up to 50 CM teams to augment practice-based care management for the Medicaid population</p> | DPW, CM teams funded independently and established within ACOs |

(continued)

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Appendix Table 19A-1. Models and strategies proposed in Pennsylvania Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|--|--|--|---|---|
| Health IT and enhanced data analysis Performance measures Health information exchange (HIE) Telemedicine | Currently required reporting of performance measures HIE: DPW providing financial incentives for EHR development and building HIE infrastructure, PA Telestroke Network, Quality Insights of PA building infrastructure Telemedicine: exists in children’s hospitals | Performance measures: PCMHs, APOs, CM teams, providers, payers, patients HIE: PCMHs, APOs, hospitals, patients Telemedicine: PCMHs, APOs, hospitals, providers, payers, patients | Proposed executive branch actions *Performance measures: State purchasing contract requiring Medicaid providers receiving EHR incentive grants to provide PHC4 Meaningful Use clinical quality measures (requirement phased in over a 3-year period) *HIE: State purchasing contract requiring APOs that wish to contract with Medicaid PCMHs to meet minimum standards for their EHR systems Pursue Round 2 Model Test award to fund health IT investment Proposed state legislative and regulatory actions *Performance measures: Legislation reauthorizing PHC4 *Consensus reports and performance measures: Legislation authorizing collection of emergency department and other data for some payers *HIE and Telemedicine: State budget allocation to invest in HIE and telemedicine infrastructure Telemedicine: Privacy regulation changes to remove barriers to exchanging clinical information for the purposes of improving clinical care (to be determined) | Performance measures: DPW, PHC4 for data analysis HIE: eHealth Authority connecting local HIEs, PHC4 for data analysis Telemedicine: Pennsylvania Telemedicine Advisory Committee, PHC4 for data analysis |

(continued)

Appendix Table 19A-1. Models and strategies proposed in Pennsylvania Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|--|--|-----------------------|---|---|
| Workforce development Changes focused on clinicians, behavioral health practitioners, dental providers | Pittsburgh Regional Health Initiative training program and materials, various medical schools' training programs | N/A | <p>State facilitation of system change</p> <p>*Performance measures: State convener of voluntary alignment among providers and payers to develop consensus reports concerning individual patients with common elements and formats and development of a core measure set for performance comparisons</p> <p>HIE: State government–led coalition to drive voluntary change among private payers and providers</p> <p>Proposed state legislative action</p> <p>*State budget appropriation for a loan repayment program with incentives to providers across a number of clinical disciplines who have received PCMH training, are working in underserved areas at safety net sites, or are working in sites affiliated with health care organizations that demonstrate care delivery transformation</p> <p>State facilitation of system change</p> <p>Health professional programs and schools change curriculum voluntarily</p> | Transformation Support Center and its regional hubs |
| Public health strategies Priority issues will be developed, such as healthy eating, exercise, and lowering tobacco use | County and municipal-based health departments | General population | <p>Proposed state legislative action</p> <p>*State budget allocation to develop a SHIP, develop tasks forces to address statewide priority areas, and establish a health improvement partnership program</p> | DOH and private stakeholder advisors, libraries, local health departments |

(continued)

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Appendix Table 19A-1. Models and strategies proposed in Pennsylvania Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|---|---|-----------------------|--|--|
| Infrastructure to support delivery system transformation Lead Plan implementation through new Center for Practice Transformation and Innovation Establish Transformation Support Center and hubs | None | N/A | Proposed state legislative actions *State budget allocation for Center for Practice Transformation and Innovation Proposed executive branch action *State purchasing contract for organizations to establish Transformation Support Center hubs | Center for Practice Transformation |

¹Policy levers include Medicaid waivers; federal grants (including Round 2 SIM award); state laws; state regulations; state investments (e.g., in public health programming); foundation grants; employer-led coalitions to drive change among providers, purchasers, or plans; state government-led coalitions, task forces, or commissions to drive voluntary change among providers, purchasers, or plans; state purchasing contracts; and state-level (Governor-initiated) executive policy directives.

Abbreviations: ACO = accountable care organization, APO = accountable provider organization, CHIP = Children’s Health Insurance Program, CM = community-based care management, DOH = Department of Health, DPW = Department of Public Welfare, EHR = electronic health record, EOC = episodes of care, HIE = health information exchange, health IT = health information technology, MCO = managed care organization, N/A = not applicable, PCMH = patient-centered medical home, PEBTF = Pennsylvania Employee Benefits Trust Fund, PHC4 = Pennsylvania Health Care Cost Containment Council, SHIP = State Health Improvement Plan.

20. Rhode Island

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Rhode Island’s health care landscape is dominated by fee for service, although its state leadership is committed to payment reform, and the state’s Medicaid program has already implemented managed care for a majority of its beneficiaries. To develop Rhode Island’s Health Care Innovation Plan (the Plan), the state launched the Healthy Rhode Island initiative, relying largely on the Healthcare Reform Commission—an organizational structure established in 2011 to help the state advance health care reform initiatives. With Lieutenant Governor Elizabeth H. Roberts’ office spearheading the effort, both state government and nongovernment health care stakeholders (including payers, providers, and community-based organizations) were engaged throughout the Plan development process, with the Advisory Board Company (ABC) providing consulting services—although the state explicitly reserved the right to make Plan decisions.

The keystone of Rhode Island’s Plan is to encourage further development of patient-centered medical homes (PCMHs) by building off the state’s long-running Chronic Care Sustainability Initiative-Rhode Island (CSI-RI), a multi-payer effort launched in 2008. Rhode Island believes that patient-centered medical care, along with new payment models that value transparency and outcomes (the Plan notes pay-for-performance, bundled payments, and shared saving arrangements as enabling alternatives), will help transition the health care environment to a more value-based and accountable health care delivery model. By supporting and expanding CSI-RI and other PCMH programs, and introducing new payment methodologies, the state hopes to reach 80 percent of Rhode Islanders within 5 years, although phase-in benchmarks are not explicit in the Plan. The main policy levers would be to use the state’s own purchasing power plus the state Health Insurance Commissioner’s regulatory authority and rate review process to set commercial payment standards. Otherwise the state would rely mainly on voluntary action to move the health care system forward.

20.1 Context for Health Care Innovation

The Lieutenant Governor’s office, in collaboration with ABC consultants, developed the Plan in the context of: (1) a long history of health care reform efforts and a commitment to move away from fee-for-service (FFS) reimbursement toward a value-based framework (Healthy Rhode Island, Final Plan, 2013); (2) state legislation creating the Office of the Health Insurance Commissioner (OHIC) and subsequent expansion of the commissioner’s regulatory authority beyond traditional insurance regulation to policy development; (3) promulgation of PCMH through state and federally supported initiatives; (4) a health insurance market characterized by a dominant insurance issuer, Blue Cross Blue Shield of Rhode Island (BCBSRI), covering more

than 70 percent of commercially insured lives in the state, and the majority of the state's primary care physicians operating in small or solo practices (Healthy Rhode Island, Final Plan, 2013); and (5) Governor Lincoln Chafee's September 2013 announcement that he would not seek reelection in 2014 (Gregg and Marcelo, 2013) and Lieutenant Governor Roberts reaching her term limit the same year. All these factors influenced both the planning process and Plan content.

Rhode Island's health care marketplace is dominated by FFS, with very little managed care penetration outside Medicaid. In the early 1990s, Rhode Island's Medicaid program began to transition many of its populations from traditional FFS into managed care. The Rhode Island Medicaid Reform Act of 2008 (Section 42-12.4-7) called on the state's Secretary of the Department of Human Services to submit the Global Consumer Choice Compact Medicaid section 1115 waiver application, which among other things required that Medicaid beneficiaries have a medical home (Rhode Island Department of Human Services, 2011). Currently, 73 percent of Rhode Island's Medicaid beneficiaries are enrolled in managed care plans (Harvey, 2011). For privately insured Rhode Islanders, however, most health care is delivered through FFS models. The state's health care landscape is also characterized by a heavily concentrated insurance market, with the two insurers (BCBSRI and United Healthcare) covering 97 percent of commercial lives (Healthy Rhode Island, Final Plan, 2013).

Rhode Island enacted legislation in 2004 creating OHIC, a new state agency directed to oversee health insurance—the only one in the nation (Buntin, 2011). Since its inception, this office has been influential in shaping the state's health reform landscape, in particular spearheading several efforts to better coordinate primary care for Rhode Islanders.

To increase the spread of PCMH within the state, OHIC introduced regulatory reforms in 2010 for commercial health insurers with significant market share in the state. These reforms, known as Affordability Standards, require insurers to expand and improve primary care infrastructure; spread adoption of patient-centered medical care; support CurrentCare, the state's health information exchange; and work toward comprehensive payment reform.

In 2008, OHIC convened state payers—including Medicare, providers, and purchasers—to form CSI-RI to support development of PCMHs. CSI-RI now covers 250,000 Rhode Islanders, with the goal of covering 500,000 residents (half the state's population) by 2015 (CSI-RI, 2013). In an ongoing pilot program, CSI-RI is using Community Health Teams (CHTs) to help smaller practices coordinate care for high-risk, high-cost patients, and plans to increase the number of available CHTs over the next 5 years.

Rhode Island's private sector has also supported efforts aimed at promoting primary care. To facilitate the spread of PCMH among solo and small physician practices, for example, BCBSRI in 2013 signed a contract with an association representing 150 primary care physicians (covering 80,000 lives) in the state to establish a medical home program. For some practices,

this complements CSI-RI, although BCBSRI has negotiated its own care management contracts with participating providers, who receive a monthly fee to actively engage chronically ill patients and invest in a primary care team. BCBSRI also joined forces with a hospital in 2013 to create a “Medical Neighborhood,” where small group or independently practicing physicians can rely on the hospital to provide PCMH services for complex patients.

In addition, the state has capitalized on a number of opportunities presented by the Patient Protection and Affordable Care Act (ACA) to move toward a more patient-centered, value-based delivery system. For example, in 2011 CMS approved two state plan amendments for Medicaid Health Homes (Section 2703) to improve the coordination of care for adults and children with serious mental health problems, by co-locating primary care and mental health care services. Although the health homes initiative operates outside the CSI-RI framework, its focus is also on improving the care coordination for high-risk individuals.

Providers in Rhode Island are participating in a number of other federally supported demonstration programs that may further support health care transformation—including the HealthCare Innovation Awards, the Federally Qualified Health Center (FQHC) Advanced Primary Care Practice, the Community-based Care Transition Programs, and the Advance Payment Accountable Care Organization (ACO) Model. In addition, Medicare is a participating payer in CSI-RI through the Multi-Payer Advanced Primary Care Practice Demonstration. And the state has made initial investments in an all-payer claims database (APCD)—a collaborative effort among the Rhode Island Department of Health, OHIC, HealthSource RI (the state’s ACA marketplace), and the Executive Office of Health and Human Services (EOHHS). The APCD will include data on medical claims, pharmacy claims, health care providers, and member enrollment; collection from all major insurers doing business in the state, Medicaid, and Medicare began in January 2014.

Finally, the unexpected announcement by the Governor that he would not seek reelection—combined with the fact that the Lieutenant Governor, who led the Plan process, was reaching her term limit—has created uncertainty about the future direction of state health care reform efforts.

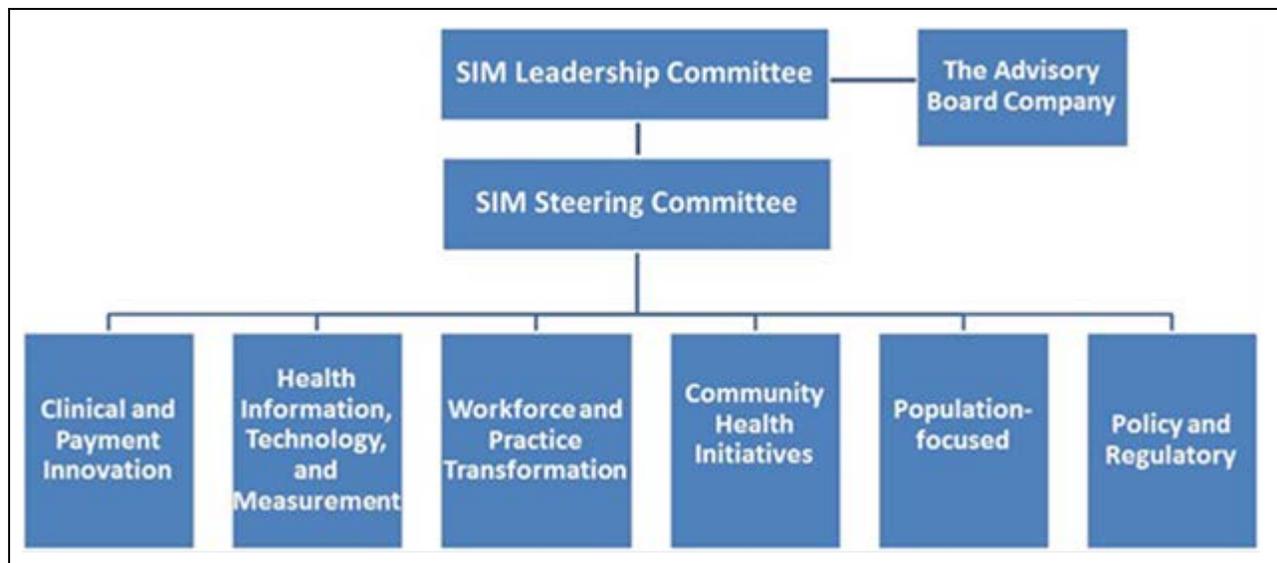
20.2 Planning Infrastructure and Process

Overall, stakeholders agreed that Rhode Island’s Plan infrastructure and stakeholder process was well managed and effective at engaging a broad and diverse group of stakeholders from across the health care community. Many stakeholders commended the Lieutenant Governor and her Office for leading the SIM effort with much skill, drawing on her previous experience in convening stakeholders around implementation of the ACA. Many commented on how the Plan design process was a genuine effort to engage stakeholders in the Plan design that brought about unprecedented levels of collaboration among organizations and entities with

shared interests. Some payer and provider stakeholders, however, noted that although building tactical relationships may have been a welcomed byproduct of the process for some participants (such as community-based organizations), it may have actually detracted from the task at hand. Since much time was reportedly spent on educating such participants about programs and initiatives already under way in Rhode Island, not enough time was dedicated to developing strategies for meaningful reform. Finally, a common complaint among stakeholders, both state government and nongovernment, was lack of available data and financial analyses during the planning process.

Governance, management, and organizational structure. As noted, the Governor delegated the planning effort to the Lieutenant Governor, who was also principally responsible for drafting the SIM application and led the Initiative with the consultancy and project management assistance of ABC. At the top of the Initiative’s planning infrastructure (*Figure 20-1*) was the Leadership Committee, which was convened by the Lieutenant Governor on a biweekly basis and consisted of state agency and department heads. The SIM Steering Committee, which met weekly, comprised senior staff from several state agencies—including the Department of Health, OHIC, EOHHS, HealthSource RI, the Governor’s Office, and the Lieutenant Governor’s Office. Besides managing the Plan process, the Steering Committee was responsible for screening work group recommendations and compiling a list of the most promising innovations for final approval by the Leadership Committee. To ensure the project was on track, weekly update meetings between ABC staff and the Lieutenant Governor Office’s staff took place throughout the course of the project (Healthy Rhode Island, First Quarterly Report, June 30, 2013).

Figure 20-1. Healthy Rhode Island planning infrastructure



Work groups formed the foundation of the overall planning infrastructure and the innovations generated by each work group ultimately formed the basis of the Plan. The Leadership Committee, inspired by the headings in the SIM award application, created six such groups: (1) Clinical and Payment Innovation; (2) Health Information, Technology, and Measurement; (3) Workforce and Practice Transformation; (4) Community Health Initiatives; (5) Population-focused; and (6) Policy and Regulatory. Each work group was designed to be led by a group of individuals, including state officials and private sector representatives, who functioned as content and policy leads and facilitated the meetings. But some work group participants said meetings seemed primarily led by one state person. ABC consultants were also involved in leading some of the work groups.

The Rhode Island legislature was not substantially involved in Plan development, although several representatives participated to some degree in work group meetings. Some senior-level agency turnover and dwindling participation of HealthSource RI staff because of the impending launch of the marketplace also occurred. While no direct state or private resources were used to fund the planning process, several state agencies, including the Lieutenant Governor's Office and the Department of Health, assigned staff as an in-kind contribution to the project. In addition, project meeting space was provided by Brown University and the Rhode Island Quality Institute.

Stakeholder engagement in work groups. Even though some stakeholders voiced initial skepticism that the state had already developed the Plan and was engaging stakeholders only for “window dressing,” these concerns had largely dissolved by the end of the process. Even so, some stakeholders said certain stakeholder groups, particularly major providers and leading innovators such as CSI-RI, may have had more influence than others in formulating the ideas that eventually made it into the Plan. Stakeholders were generally satisfied with the level of communication between the Plan leadership team and work group participants and described the Lieutenant Governor's Office as approachable and responsive to feedback.

The Healthcare Reform Commission, established in 2011 to help guide the state in its reform efforts, informed the strategy for stakeholder engagement in the Healthy Rhode Island initiative, according to state officials. Work group participation was encouraged with “open membership,” and “anyone who showed up had an equal seat at the table,” as described by a state official. Nongovernment stakeholders agreed there were ample opportunities to voice opinions and provide suggestions, including directly to the Lieutenant Governor's Office. Overall, stakeholders were pleased with the level of stakeholder involvement and the collaborative nature of the planning process, and felt that everyone who needed to be at the table was present. Some, however, noted that large attendance made it difficult to partake actively in some work group meetings.

The planning effort kicked off at an April 2013 meeting attended by more than 100 members of Rhode Island's health care community. Stakeholders said meeting notices were circulated widely and posted on the Healthy Rhode Island Web site to ensure transparency and broad participation. After the kickoff meeting, stakeholders were invited to self-select into one or more of the six work groups.

Each work group held meetings six to eight times during the summer, which were open to the public and were generally well attended; 25 to 50 people typically attended work group meetings, according to state officials. Each work group was tasked with identifying innovative models and policy levers to be included in the Plan. Some stakeholders commented that, although initially information was lacking about what other work groups were discussing, the leadership organized a mid-process cross-pollination meeting to exchange ideas and avoid duplication or overlap. The work group meetings culminated in early September 2013 with each submitting its recommendations for the Plan to the SIM Steering Committee. The only exception was the Policy and Regulatory group, which was primarily tasked with reviewing other work group recommendations (Healthy Rhode Island, Second Quarterly Report, September 30, 2013).

Other stakeholder engagement. The Lieutenant Governor personally invited more than 50 key stakeholders to take part in the Plan development process, holding several one-on-one meetings with major stakeholders to ascertain their assessment of Rhode Island's health care environment and recommendations for improving it. After the draft Plan was developed and endorsed by the Leadership Committee, work group participants were invited to attend one of several public meetings, in which the draft Plan was presented prior to release to the general public on November 6, 2013.

Apart from the work groups, ABC conducted more than 50 interviews with key members of the Rhode Island health care community, to obtain candid assessments by both internal and external stakeholders of the health care environment and reform efforts. A summary of findings from these interviews was presented to both the Steering and Leadership Committees, and to all work group participants (Healthy Rhode Island, Second Quarterly Report, September 30, 2013)—although it is not clear to what extent the ideas gathered from these interviews informed Plan development. The general public was invited to submit comments on the draft Plan during a 3-week public period in November 2013.

Several stakeholder groups were noted by interviewees as missing from the process. Some pointed out the limited presence of specialists and independent physicians not affiliated with a larger practice group. Others observed that the business community was not involved to any great degree. Still others noted that consumers were lacking representation. One commented that deans of a local nursing school were not aware of the SIM effort. Given that workforce and

practice transformation was part of the Plan, this stakeholder felt the deans should have been included.

Decision-making process. Although stakeholder engagement was viewed by state officials as being inclusive, they said that decision-making authority regarding strategies to be included in the Plan still rested with the state. As one official put it: “Our model is that we strive for but do not require consensus.” Nongovernment stakeholders reported being unclear as to: (1) how final decisions were made about what to include in the Plan, and (2) who in fact made these decisions.

20.3 The Rhode Island Plan

The primary goal of Rhode Island’s Plan is to transition the state’s current fragmented delivery system, based largely on FFS reimbursement, to a more coordinated and integrated system in which reimbursement is tied to value. The state plans to build on several existing initiatives, most prominently its longstanding PCMH program, CSI-RI. It also proposes numerous other strategies and policies to support the transition toward value-based care, including payment and delivery system reforms; investments in workforce development, public reporting, and health information technology (health IT); building infrastructure to support health system transformation; and population health efforts. The Plan proposes that all payers—including Medicaid, Medicare, and commercial insurers—be involved in implementation.

One of the main policy levers the state would use to drive payment transformation is the regulatory authority bestowed on OHIC through legislation passed in 2012, which allows the commissioner to set standards for commercial payments to providers and use the rate review process to encourage transition to alternative payment methodologies that support value-based care. In addition, Rhode Island plans to leverage its purchasing power to require value-based care contracting arrangements from the state employee health plan and health plans that contract with Medicaid. Rhode Island’s Medicaid section 1115 waiver will serve as the basis for making changes to Medicaid payment. Other policy levers identified in the Plan are changes to state laws, including legislation to expand access to a PCMH to all Rhode Islanders, investments in health IT, and use of multi-stakeholder coalitions to guide and support delivery system transformation. The intended result of the Plan is to ensure access to value-based care for at least 80 percent of Rhode Islanders within 5 years.

20.3.1 Models and Strategies

Rhode Island proposes a wide variety of models and strategies in its draft Plan, which some stakeholders, particularly payers and providers, characterized as “too diffused.” These can be roughly categorized as follows: (1) PCMH model, (2) payment transformation, (3) delivery system reorganization, (4) workforce development, (5) infrastructure to support health care

system transition and population health, (6) public health interventions, (7) enhanced health system data analysis and public reporting, and (8) investment in health IT. A summary description of the innovations proposed in the Plan can be found in [Appendix Table 20A-1](#), initiatives on which they are built, populations they address, and supporting policy levers and entities.

PCMH model. Rhode Island plans to build on several of its ongoing multi-payer initiatives, most prominently the CSI-RI and BCBSRI's PCMH initiative. The state's goal is to continue statewide development of the PCMH model, eventually ensuring access to PCMHs for all Rhode Islanders by 2020. The Plan also proposes to expand the traditional PCMH to include pediatrics, and to involve specialists and hospitals to support the "Medical Neighborhood" concept.

Activities already under way to support further development of the PCMH model include: (1) OHIC requirements to honor the common contract developed in support of the PCMH from insurers participating in the fully insured market and (2) incentives for individuals shopping for coverage through HealthSource RI to select plans built around the PCMH concept. The Plan is silent about whether any accreditation, licensing, or PCMH recognition requirements will be adopted or developed for participating providers.

Payment transformation. To move away from FFS and encourage new payment models that support value-based care, Rhode Island proposes to use OHIC's regulatory authority and the health plan rate review process to set standards for commercial payments to all health care providers. In addition, the state intends to leverage its purchasing power to require value-based care contracting arrangements from both the state employee health plan administrator and health plans that contract with the Medicaid program. The Plan indicates that the new payment models may include pay-for-performance, bundled payments, and shared savings arrangements such as ACOs. Importantly, however, Rhode Island's Plan does not commit itself to any specific payment methodology; nor does it elaborate on how existing payment initiatives would be incorporated into the Plan payment transformation. Although stakeholders believed the ACO model in particular could play a significant role in Rhode Island's health care innovation strategy, the Plan does not discuss ACO-like models as part of the foundation for developing an integrated care system. Instead, the Plan calls for voluntary changes from providers, insurance carriers, and community-based organizations to modify the health care market to be more value based and outcomes oriented. The Plan does, however, promise to provide technical and financial assistance in this transition, contingent on further Round 2 funding (Healthy Rhode Island, Final Plan, 2013).

Delivery system enhancements. In an effort to reorganize its delivery system, the Plan envisions a significant role for CHTs in providing care coordination and management, both outside the clinical setting and within primary care practices. CHTs are to include nurses, social

workers, dieticians, pharmacists, and other professionals who would play a vital role in care coordination and treatment follow-up. Rhode Island is also planning specialized CHTs to focus on specific populations, including persons with behavioral/substance abuse problems and other chronic conditions. CHTs are also to include community health workers (CHWs) trained to help patients navigate the health care system and connect them with social services organizations and community-based resources (such as housing assistance, nutritional assistance, and job training). The state plans to expand CHTs to all Rhode Islanders within 5 years, and envisions CHTs becoming a shared resource among providers, particularly smaller physician practices participating in PCMH programs.

Another major delivery system reform proposed in the Plan is integrating behavioral health with other parts of the health care system. Specifically, the Plan proposes to build on the successes of the state's Medicaid Health Homes demonstration by co-locating behavioral health services and supports with primary care delivery—in an effort to increase screening for behavioral health problems and access to primary care for patients with behavioral health diagnoses. It is unclear whether this integration effort would affect all relevant providers or just those participating in the PCMH model of care.

Finally, the state addresses emergency department overuse by proposing to establish intermediate-intensity services—such as home-based primary care, ambulatory intensive care units, and sobering centers—for the highest users of emergency departments, especially among Medicaid and Medicare beneficiaries.

Workforce development. The Plan proposes three main activities to build a health care workforce that will support the transition to a value-based care system. First, Rhode Island envisions integration of CHWs in CHTs, as described above. Toward that end, the state would develop uniform credentials, training, and licensing requirements for CHWs. Second, the state plans to conduct a comprehensive workforce assessment to determine the current workforce supply and project future needs. Lastly, the state proposes to align education and training of the health care workforce with principles of a value-based system, by developing a collaborative care model curriculum and encouraging its adoption by educational facilities.

Infrastructure to support delivery system transformation. The Plan proposes to build new infrastructure to support the transition to value-based care and population health efforts. Chief among the components of such an infrastructure is the Rhode Island Care Transformation and Innovation Center (RICTIC)—envisioned as a public-private partnership that would be primarily responsible for convening a multi-stakeholder coalition and providing assistance to providers and payers adopting new models of care and payment.

In support of population health efforts, another proposed infrastructure change is to improve integration of community-based organizations into the health care system, with CHTs

serving as coordinators between community-based groups and primary care practices. The Plan proposes developing comprehensive provider and community service resource directories to be made available to state agencies, providers, payers, and consumers. There is no mention of integrating existing directories—such as Ask Rhody (an online information service provided by EOHHS that allows individuals, agencies, and organizations to search for social services agencies and their services and determine eligibility for state-funded programs)—into such a resource.

To help patients navigate the reformed health care system environment, the Plan suggests establishing a Navigator program modeled after the consumer assistance program used by HealthSource RI. The Plan also proposes developing a System Ombudsman entity to monitor the effectiveness and ease of navigation of the system and to address any problems that may arise.

Public health strategies. The Plan proposes several public health strategies to broadly improve the health of Rhode Islanders. Among other things, the state would promote inclusion of health, prevention, and patient engagement strategies into state and city planning, with the goal of increasing the state’s accountability for the population’s overall health. To ensure that every resident, regardless of type of insurance, has access to preventive care, the Plan proposes to establish a statewide funding mechanism to provide these services.

To involve Rhode Islanders in their own health, the Plan calls for strategies to increase awareness and encourage enrollment in its existing statewide health information exchange system, CurrentCare, which would include a patient portal to enable patients to collect their personal health data. The Plan also proposes that health plans and employers require compulsory health risk assessment, to help citizens understand and address their risks of developing chronic and other health conditions.

Enhanced data analysis and public reporting. The Plan calls for continuing to develop the APCD, so it can monitor population health and health care payment and utilization patterns. Details for which state-sponsored entity would coordinate the APCD do not appear in the final Plan, however.

Health IT. To promote utilization of health IT, the Plan proposes to incorporate financial incentives in providers’ contracts to encourage adoption of electronic health records and participation in CurrentCare. In addition, the state would continue to develop and adapt the interoperability and usability of health information systems, including CurrentCare and the APCD—such as developing “single sign-on” capabilities—to make health IT systems more user-friendly.

20.3.2 Policy Levers

Rhode Island sets out several policy levers to advance implementation of its Plan. The main policy levers are discussed here; additional ones are included in [Appendix Table 20A-1](#). Rhode Island’s proposals for delivery system reforms rest largely on successful initiatives already established in the state, including the CSI-RI and BCBSRI’s PCMH initiative. An amendment to the Rhode Island All-Payer Patient Centered Medical Home Act is proposed to be introduced in 2014 to “affirm” the state’s commitment to expanding the PCMH model to all Rhode Islanders by 2020, according to the final Plan. To assist smaller practices in transitioning to the PCMH model of care, Rhode Island proposes to deploy CHTs, currently being piloted by CSI-RI in two communities. The plans for scaling up CHTs also include leveraging the 2011 legislation that created an explicit role for CHWs in addressing health disparities in the state.

To realize the payment transformation objectives, the state intends to leverage its purchasing authority to set contracting requirements for health plans that contract with the state’s Medicaid managed care program to drive value-based purchasing for all health care services. Changes to the payment structure in the Medicaid program can be carried out within the state’s Medicaid section 1115 waiver, for which the state is currently reapplying. Rhode Island plans to use the same lever to require insurers that contract to cover state employees, municipal employees, and retirees to align their payment methodologies with value-based care principles.

Another important policy lever to achieve payment reform is the regulatory power of OHIC. Pursuant to the amendment to the Rhode Island Health Care Reform Act of 2004, OHIC is charged with ushering in “the transition from fee for service and toward global and other alternative payment methodologies for the payment for health care services.” This authority has helped OHIC require increasing investments in primary care from commercial payers, setting a precedent for future reforms. Going forward, the Plan states that OHIC will propose regulations that require 80 percent of commercial payments to all health care providers to be value based, making this change incrementally over the next 5 years. These regulations would affect not only the individual and small group markets and but also the self-insured market to some degree.

Some proposed innovations lack sufficient description of how they would be implemented. For example, the Plan does not provide details about how the intermediary services for high utilizers would be created; nor is it clear which levers would be used to create uniform credentialing for CHWs and develop value-based care training curriculum. The Plan also fails to identify concrete policy levers that could facilitate implementation of the strategies it lists as infrastructure investments. In particular, RICTIC seems to have a prominent role in facilitating health care system transformation, yet the Plan falls short in detailing steps required to establish this entity. Similarly, policy levers for some public health strategies, such as incorporating health awareness into city planning, are not well articulated. The Plan also states that OHIC will be involved in implementing health risk assessments but does not specify

whether it already has authority to do so. Finally, the Plan does not provide clear policy levers for promoting greater health IT adoption among providers—other than alluding to leveraging OHIC’s regulatory powers to require inclusion of electronic health record incentives in provider contracts from all major payers. Levers for increasing interoperability of health IT systems are similarly vague.

20.3.3 Intended Impact of the Plan

To improve the health of its residents and lower the cost of health care while improving quality, Rhode Island proposes to transition its delivery system within 5 years to one where at least 80 percent of the state’s population will receive their health care from providers that receive value-based payments from insurers. Most stakeholders believe that when implemented, the Plan can affect more than 80 percent of Rhode Island’s population, with some caveats.

20.3.4 Proposed Next Steps

Neither the draft nor the final Plan offers much information about which entity, existing or new, would be responsible for leading and overseeing implementation of the Plan. Some stakeholders expressed concerns about the lack of executive leadership at the state level and uncertainty about the future of the project, particularly given the already noted departure of both the Governor and Lieutenant Governor in 2014. Some stakeholders were also concerned about the diffusion of power at the state level, with various state agencies and departments having different responsibilities and restrictions. Stakeholders felt that it would be important to have one coordinating and decision-making entity to lead and oversee Plan implementation. Stakeholders almost universally implied interest in pursuing a Model Test award; but, again, neither the draft nor the final Plan clearly articulates the steps to be taken after/if the state receives Model Test funding. Nor is there mention of whether the Plan would be implemented without such funds. The final Plan includes a financial analysis, which stipulates that the cost of implementing the Plan would be shared by providers, health systems, payers, and government.

20.4 Discussion

Although stakeholders had mixed reviews about the draft Plan, most believed the Plan is feasible, largely because of the small scale of Rhode Island’s health care system and its longstanding history of health care reform. Contributing to stakeholders’ optimistic view was the Plan’s centerpiece—expanding the CSI-RI model—which already involves major health care stakeholders. Some stakeholders, however, felt that: (1) the Plan did not advance health care innovation in Rhode Island and, again, (2) the departures of both the Governor and Lieutenant Governor at the end of 2014 raised implementation concerns.

20.4.1 Critical Factors That Shaped the Plan

Several factors influenced development of the Plan. Chief among them was the presence of existing programs, in particular CSI-RI. Rhode Island proposes to build a collaborative approach to an integrated health care system that would include measurement strategies, data reporting, and payment strategies that support value-based care. Existing private health care initiatives were also noted as playing a role in shaping the Plan, including PCMH arrangements with several hospitals within the state. Some stakeholders felt that to bring about health care innovation in Rhode Island, the Governor needs to be “the driver and champion,” and that the Governor’s decision not to seek reelection leaves somewhat of a political void for the state—although others noted that the Governor has not been a champion of health, but rather “delegated health care reform to the Lieutenant Governor.” At the same time, as one stakeholder remarked: the “marketplace waits for no one.” Finally, stakeholders almost universally described the planning process as inclusive, and as seeking consensus from all stakeholders. The downside to this approach noted by some respondents was that it makes it difficult to drive real innovation where “sacrifices” from a number of people in the room are required in a shrinking system. As a consequence, some observers felt the Plan does not sufficiently advance Rhode Island along the innovation continuum and is not focused on outcomes.

20.4.2 Lessons Learned

Rhode Island’s participation in the Model Design process offers several lessons states and the federal government can draw on as they embark on similar initiatives, according to stakeholders.

- **Start planning before you start planning.** Even though almost all interviewees agreed the planning time was sufficient to keep the participants focused without wearing them out, many expressed the desire for more upfront education around existing services and initiatives. The lack of understanding and appreciation for some of the important initiatives (e.g., CSI-RI) was frustrating to participants actively involved in these efforts and took away from planning time. In addition, some suggested the state could have involved major players before submitting the application for the Model Design funding.
- **Broad stakeholder engagement may cause diffusion.** A prevalent opinion among health care providers and payers was that too many people were in the room and too many ideas were put forth to focus the discussions around a strategy that would bring about innovation. Although the need for transparency and inclusion was certainly appreciated, the process was perceived as almost too open, where facilitation of a 90-minute meeting with 50 participants became difficult and resulted in a diffuse draft Plan. Providers and payers thought recommendations should come from a smaller group consisting of major players in the market and state representatives.

- **Planning process needs to be data-driven.** A major obstacle in designing the Plan was said to be lack of available data on health care costs and utilization. Several stakeholders—including payers, providers, and state officials—expressed regret at not having more robust data on health care spending to better identify areas of concern and opportunities for savings. ABC subcontracted with Milliman and Robertson to conduct financial analyses, but these were not completed until after the work group meetings had concluded. Some initial analyses indicated disproportionately high spending on behavioral health, for example, but there was insufficient time to identify major drivers of spending or potential interventions.

20.4.3 Potential for Implementation

The draft Plan received mixed reviews from stakeholders and some refrained from making judgments, recognizing that the Plan at that time was not final. The main critique of the draft Plan was that it outlined high-level goals but failed to include specifics about how to achieve these objectives. Although most agreed that the draft Plan was on the right path, stakeholders felt some level of disappointment that it was not innovative enough—building off existing initiatives rather than developing new and different strategies.

Nevertheless, most stakeholders believed that the main goal identified in the draft Plan—placing 80 percent of the population in a value-based purchasing arrangement—was feasible, mostly because of the small scale of Rhode Island’s health care system and the state’s longstanding history of health care reform. With BCBSRI on board and the addition of Medicaid beneficiaries and state employees, the consensus seemed to be that more than 80 percent of the state’s population could, indeed, be affected.

The impending change in Rhode Island government leadership was viewed by many as a potential threat to Plan implementation. Although the Lieutenant Governor’s office received high marks for running the SIM planning process, many stakeholders were concerned about her lack of authority to drive the change, not to mention the fact that both she and the Governor will be leaving office at the end of 2014. As long as the new Governor is committed to health reform, stakeholders remained optimistic about feasibility of the Plan’s implementation.

Some stakeholders were also concerned about diffused leadership at the state level, as noted, with many agencies and departments having different responsibilities and restrictions and the absence of a single entity with comprehensive oversight. Lack of high-level leadership at the state level was also seen as potentially threatening implementation efforts.

The level of enthusiasm and support for health care reform in general is high in Rhode Island, and even though stakeholders concurred that the draft plan needed more work, they remained hopeful and excited about the possibility of receiving Round 2 funding to improve health care for Rhode Islanders.

20.4.4 Applicability to Other States

Rhode Island is a geographically small state with a population of just over 1 million in 2013. Demographically it is homogeneous, with some 76 percent of Rhode Islanders classified as white, non-Hispanic. Its health care market is also heavily concentrated, with one issuer dominant. These and other factors make Rhode Island quite distinct from most other states. The Plan's general content and the initiatives proposed do not rely on characteristics unique to Rhode Island, so they could likely be applied in other states. The specifics were informed by the extent of prior progress in Rhode Island and on other unique circumstances, however, according to stakeholders. As to Rhode Island's Plan stakeholder engagement process, it could be hard to duplicate in a larger state, particularly the involvement of high-level state and private sector stakeholders.

20.4.5 Limitations of This Evaluation

Although we draw on information in both the draft and final Plans for this case study report, interviews—our other major information source—were conducted between October and December 2013, before the Plan was finalized. Another constraint on the analysis is that some key state stakeholders declined to participate or had a schedule that did not permit an interview.

20.5 References

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Appendix Table 20A-1. Models and strategies proposed in the Rhode Island Health Care Innovation Plan

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands (if any) | Populations proposed to be addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|---|--|--------------------------------------|---|--|
| <p>PCMH model Encourage the further development of PCMHs</p> | <p>CSI-RI Blue Cross Blue Shield’s PCMH</p> | <p>General population</p> | <p>Existing</p> <p>*Rhode Island All-Payer Patient-Centered Medical Home Act signed into law in 2011 and amended in 2013 to include participation of state employees</p> <p>Medicaid Section 1115 Waiver, the Global Consumer Choice Compact (requires all Medicaid beneficiaries to have a medical home)</p> <p>Federal Demonstration awards: Federally Qualified Health Center Advanced Primary Care; Multi-payer Advanced Primary Care Practice</p> <p>Proposed state legislative action</p> <p>*Introduce legislation in 2014 to affirm commitment to PCMH expansion to the entire population</p> <p>State facilitation of system change</p> <p>Use Community Health Teams in providing support to small practices that will be transitioning to PCMHs</p> | <p>OHIC, HealthSource RI (state-based health insurance marketplace)</p> <p>Multi-payers—private insurers, Medicare, Medicaid</p> <p>Providers—private practices, community health centers, community mental health organizations, CSI-RI</p> |

(continued)

Appendix Table 20A-1. Models and strategies proposed in the Rhode Island Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands (if any) | Populations proposed to be addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|---|---|---|--|---|
| Payment transformation Develop value-based options for state and municipal employees, retirees, and Medicaid fee-for-service members Set contracting standards | Advance payment ACO model for Medicare (Coastal Medical) Bundled payments for Care Improvement Initiative Medicaid managed care program | State and municipal employees and retirees Medicare Dually eligible Medicaid/Medicare beneficiaries General population | <p>Existing</p> <p>The Rhode Island Health Care Reform Act of 2004—Health Insurance Oversight, Section 42-14.5-3</p> <p>*Medicaid section 1115 waiver</p> <p>Federal Demonstration awards: Advanced Payment ACO Model initiative and Bundled Payments for Care Improvement initiative</p> <p>Proposed state regulatory action</p> <p>*OHIC regulations that require all payers to transition to value-based care payment systems</p> <p>Proposed executive branch actions</p> <p>*Require third-party administrator to implement alternative payment models for the state employee health plan</p> <p>*Implement value-based payment requirements in Medicaid managed care provider contracts through modifications of the Medicaid section 1115 waiver (in process)</p> <p>HealthSource RI will set standards for insurers participating in the marketplace that are compatible with value-based care model (in process)</p> | State agencies Municipalities Multi-payer coalition—private and public insurers Providers, including behavioral health, long-term care, dental, and other subspecialties |

(continued)

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Appendix Table 20A-1. Models and strategies proposed in the Rhode Island Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands (if any) | Populations proposed to be addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|---|---|---|--|---|
| Delivery system enhancements | CSI-RI pilot CHT program in the Pawtucket and South County communities | Initially high-risk and rising risk Medicaid population, eventually general population | Existing | Community mental health organizations, CEDARR Family Centers |
| Development and use of CHTs | Health Leads and Community Action Programs—community-based programs that help connect patients to community resources | Medicaid beneficiaries (adults and children) with serious and persistent mental health issues | *Commission for Health Advocacy and Equity Act (S0481), signed into law in 2011, creates explicit role for CHWs | Multi-payer, private and public insurers |
| Co-locate behavioral health and primary care providers/co-locate primary care providers and community mental health clinics | The Community-based Care Transitions Program | Medicaid and Medicare high utilizer/high-risk beneficiaries | Federal Demonstration Award: Community-based Care Transitions Program | Providers—primary care, behavioral health, substance abuse, chronic conditions, prenatal care |
| Develop intermediate services for high emergency department utilizers | Section 2703 Medicaid Health Homes initiative | | State legislation, 2013—H 6288, creates a special joint commission to study the integration of primary and behavioral health in Rhode Island | |
| | Rhode Island’s Medicaid program “Communities of Care,” which targets high utilizers | | CMS approved state plan amendments for 2703 Medicaid Health Homes (child and adult) | |
| | | | Potential state executive action | |
| | | | OHIC to ensure that payers finance the expansion of CHTs, with some support coming from Medicaid section 1115 waiver | |
| | | | State facilitation of system change | |
| | | | Make available behavioral health data through CurrentCare | |

(continued)

Appendix Table 20A-1. Models and strategies proposed in the Rhode Island Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands (if any) | Populations proposed to be addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|--|--|--------------------------------------|---|---|
| <p>Workforce development</p> <p>Develop uniform credentials and license requirements for CHWs</p> <p>Develop curricula for in-service training for professionals and students</p> <p>Conduct workforce assessment</p> | <p>Community Health Innovations of RI training program for CHWs</p> | <p>N/A</p> | <p>Existing</p> <p>Commission for Health Advocacy and Equity Act (S0481), signed into law in 2011, creates explicit role for CHWs</p> <p>The Rhode Island Health Care Reform Act of 2013 (S0540) directs the Health Planning and Accountability Advisory Council to perform assessments of Rhode Island’s primary care workforce and behavioral health system</p> <p>Proposed executive branch actions</p> <p>Develop uniform credentials and license requirements for CHWs</p> <p>Department of Health’s Coordinated Health Planning will conduct further workforce assessments, dependent on funding</p> <p>State facilitation of system change</p> <p>In coordination with RICTIC, develop and coordinate curricula for existing health care workforce and new students, emphasizing value-based delivery of care</p> | <p>State agencies</p> <p>Medical school, health care workforce educational facilities</p> |

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Appendix Table 20A-1. Models and strategies proposed in the Rhode Island Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands (if any) | Populations proposed to be addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|---|--|--------------------------------------|---|---|
| Infrastructure to support delivery system transformation RICTIC Improve integration of community-based groups with primary care teams Develop comprehensive provider directory and social and community service resource directory Develop cadre of navigators and systems ombudsmen | HealthSource RI Navigator Program (health insurance marketplace) Existing community-based organizations | N/A | Proposed executive branch action The state will create an agency or entity to provide consumer assistance and monitor the effectiveness and ease of navigation, and identify areas in need of improvement | Public-private partnership, with most activities occurring outside state government State agencies Primary care providers Community-based groups |
| Public health strategies Encourage state/cities/towns to understand social determinants of health Create sustainable fund for prevention activities Encourage CurrentCare enrollment Complete Health Risk Assessments for all Rhode Islanders Increase public health communications | | General population | Proposed state regulatory action OHIC will encourage payers and employers to require completion of Personal Health Risk Assessments to help residents understand and address their risk of developing chronic and other health problems Proposed executive branch action Coordinate with state-based health insurance marketplace (HealthSource RI) to promote innovation/patient engagement, create patient portal into CurrentCare, and develop better coordinated public health marketing and communication campaign Proposed legislative branch action Pursue a statewide funding mechanism that would provide prevention and public health services to all Rhode Islanders regardless of coverage type | State and local governments OHIC HealthSource RI Public and private insurers Businesses |

(continued)

Appendix Table 20A-1. Models and strategies proposed in the Rhode Island Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands (if any) | Populations proposed to be addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|--|---|--------------------------------------|---|---|
| <p>Enhanced data analysis and public reporting Continue to develop APCD</p> | <p>APCD</p> | <p>N/A</p> | <p>Existing APCD legislation passed in 2008, Section 23-17.17-9 The Rhode Island Health Information Exchange Act of 2008, Section 5-37.7-1 Proposed state executive branch actions Continue to develop the APCD, including a method for de-identifying claims and clinical data outside of state operations</p> | <p>Coalition of the state, private payers, researchers, and the public</p> |
| <p>Health IT Promote use of health IT and electronic quality measurement among providers Increase usability and interoperability of health IT</p> | <p>CurrentCare (health information exchange portal) Unified Health Infrastructure Project—single technical platform that supports HealthSource RI and the Medicaid eligibility determinations KIDSNET—health information database for pediatric population Trailblazers—initiative to align health IT with health care reform efforts</p> | <p>N/A</p> | <p>Existing The Rhode Island Health Information Technology Act of 2008, Section 5-37.7-1 American Recovery and Reinvestment Act grants for health IT Proposed state regulatory action Align EHR incentive metrics and funding arrangements across major payers as a condition for value-based contracting State facilitation of system change State, in collaboration with Rhode Island Quality Institute, will support CurrentCare adoption among providers State will provide funding and technical assistance to providers, through Regional Extension Center, to help providers achieve meaningful use</p> | <p>State agencies Public and private payers Providers Rhode Island Quality Institute Rhode Island Regional Extension Center</p> |

(continued)

Appendix Table 20A-1. Models and strategies proposed in the Rhode Island Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands (if any) | Populations proposed to be addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|------------------------|---|--------------------------------------|--|--|
| | Beacon Communities Project—information technology investments and meaningful use of EHRs to support patient-centered care | | | |

Sources: Rhode Island State Healthcare Innovation Draft Plan (November 6, 2013); Rhode Island State Healthcare Innovation Final Plan (December, 2013).

¹Policy levers are defined as one or a combination of the following: Medicaid waiver; federal grants (including Round 2 SIM award); state law; state regulation; state investment (e.g., in public health programming); foundation grants; employer-led coalition to drive change among providers, purchasers, or plans; state government-led coalition, task force, or commission to drive voluntary change among providers, purchasers, or plans; state purchasing contract; state-level (Governor-initiated) executive policy directive; or other (describe).

Abbreviations: ACO = Accountable Care Organization, APCD = all-payer claims database, CEDARR = Comprehensive Evaluation Diagnosis Assessment Referral Reevaluation, CHT = Community Health Team, CHW = community health worker, CMS = Centers for Medicare & Medicaid Services, CSI-RI = Chronic Care Sustainability Initiative-Rhode Island, EHR = electronic health record, IT = information technology, N/A = not applicable, OHIC = Office of the Health Insurance Commissioner, PCMH = patient-centered medical home, RICTIC = Rhode Island Care Transformation and Innovation Center.

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21. Tennessee

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Tennessee’s State Innovation Models (SIM) Model Design process was strongly shaped by the state’s extensive experience using comprehensive managed care organizations (MCOs) to serve Medicaid beneficiaries. From the outset, Tennessee wanted its Health Care Innovation Plan (the Plan) to focus on value-based purchasing in managed care and specifically on moving the MCO payments to providers from fee-for-service payment to episode-based payment. The work of a Tennessee Hospital Association–convened Vision Taskforce set the stage for the state to quickly move to working through the details of episode-based payment implementation in its Plan, rather than using the Model Design process to develop a concept from scratch.

The Governor committed himself to the planning process, and the Governor’s Office assigned Plan development leadership to a group within the state Division of Health Care Finance and Administration (HCFA), with consulting help from McKinsey & Company. Stakeholder input was a major part of the process, although the explicit focus from the start on payment reform left physician and primary care providers, and to a less extent hospitals, feeling less than fully engaged in the process.

The Plan focuses on developing strategies for rapid implementation of retrospective payments for acute episodes of care and patient-centered medical homes (PCMHs) in 2014 and 2015. The state would use both executive branch and voluntary action as policy levers. The state plans to initially introduce episode-based payments through contracts with health plans that cover Medicaid enrollees. Two of the state’s four managed care contractors are also adopting this strategy for their state employee and privately insured populations; the state anticipates that other commercial plans will follow suit in the future. The state’s PCMH strategy builds on PCMH efforts already carried out by payers in the state. A strategy related to long-term services and supports (LTSS), developed through a separate framework, was added late in the Plan development process. The Plan predicts reaching 80 percent of the state population and projects a cost avoidance of \$3.3 billion over 3 years.

21.1 Context for Health Care Innovation

The past and current state health care market is useful for understanding the context in which the Plan was developed. Tennessee’s extensive use of Medicaid managed care, which began in 1994, is the most defining characteristic in the state’s health care market. Since 2002, the state has been operating managed care in TennCare under the second version of its Medicaid Section 1115 waiver, called “TennCare II” (Centers for Medicare & Medicaid Services [CMS],

n.d.). TennCare has remained the locus of state health reform activities—including the CHOICES-managed LTSS initiative and State Innovation Models (SIM), where the state is seeking to leverage TennCare’s purchasing power as a basis for further reform efforts.

TennCare’s long history has shaped relationships between the state executive and legislative branches, and providers, payers, and consumer groups. One stakeholder representative who is not a consumer advocate characterized the current relationship between consumer groups and TennCare as “litigious.” Provider groups indicated they had good working relationships with the state, although other stakeholders indicated that MCO contracting—which can disadvantage individual providers—resulted in frequent requests by influential providers to legislators to change the MCO framework (for example, by requiring MCOs to accept any willing provider). Payers also described good working relationships with the state, and state officials described TennCare’s relationships with providers and payers as collaborative.

Tennessee has a policy emphasis on fiscal management. According to state officials, each state agency has been requested to find reductions in their recurring state appropriations in amounts as high as 10 percent but more often around 5 percent. While every reduction was not implemented, continuous pressure is placed on the state’s tax collections trying to balance relatively low growth in collections with necessary increases to education and health care. TennCare has cut inefficiencies and administrative costs and is looking to take further steps toward models that pay for high-quality care while containing costs.

Tennessee’s approach to implementation of the Patient Protection and Affordable Care Act provides important context for its SIM Initiative. After the state decided in 2012 not to build a state-based insurance exchange (State of Tennessee, 2012), staff who had been working on exchange planning shifted to form the Strategic Planning and Implementation Group—which works on special projects for the state’s Division of Health Care Finance and Administration (HCFA), including payment reform activities under the SIM Initiative. Although the state has not yet adopted Medicaid expansion, it remains in discussions with CMS. At the outset of the Model Design process, the prospects for Medicaid expansion were positive, which providers cited as a reason for their willingness to embark on health system transformation. No stakeholders were optimistic about the prospects for Medicaid expansion in the next year. A December 2013 letter from Governor Bill Haslam to the U.S. Department of Health and Human Services Secretary indicated that implementation of the payment reform strategies developed in its Plan is essential to the state’s desired approach to expansion (Haslam, 2013).

Prior to the SIM Initiative, the most notable conversation about payment reform in the state was the Vision Taskforce, managed by the Tennessee Hospital Association and made up of providers, payers, and TennCare officials. That Taskforce began in response to payment cuts at both the federal and state levels, although 2 years ago the group shifted its focus to reducing hospital reimbursement rate variation. TennCare officials’ interest in an Arkansas-style episode-

based payment plus PCMH reform arose from their participation in the Vision Taskforce; and the other Taskforce members conceptually agreed to the idea even prior to the state submitting its proposal for a Model Design award.

Other existing efforts in Tennessee relevant to the Model Design process include several payer-led PCMH programs in the commercial and Medicaid MCO markets. In addition, a Regional Health Improvement Collaborative in Memphis has increased public reporting of data across payers and providers regionally through a multi-stakeholder effort. With regard to LTSS, Tennessee amended the TennCare II waiver to include the CHOICES program in 2010, a major initiative that brought all Medicaid LTSS into managed care, and especially increased benefits and opportunities allowing beneficiaries to choose home and community-based services rather than nursing facility care. Tennessee also undertook a major planning process to participate in the federally sponsored State Demonstrations to Integrate Care for Dual Eligible Individuals, although it ultimately withdrew from the program because of structural and programmatic concerns (Gordon, 2012). Some large employers in the state, such as FedEx in Memphis, have been engaged in regional health transformation efforts. No dominant insurer exists in the commercial market. A few nationally known providers and for-profit health care companies in the state are seen as particularly influential.

21.2 Planning Infrastructure and Process

Tennessee's Model Design efforts were supported by executive branch leadership and by a commitment of \$4 million in state funds. McKinsey & Company provided significant staffing to the planning process and fostered a focused process that allowed the state to make substantial progress on designing three initial episodes of care. Tennessee also convened influential work groups of stakeholders, including a Provider Stakeholder Group and a Payer Coalition to participate in designing the episode-based payment and PCMH models in the Plan. The state convened three Technical Advisory Groups of clinicians to design the first three episodes. In addition, the state used a series of public roundtables to inform a broad range of stakeholders on elements of the Plan and provide them with opportunities for input. The state's process resulted in a Plan that is described as feasible to implement and has general approval from payers and providers—though some stakeholders indicated dissatisfaction with their level of input to the Plan.

Governance and management. The Governor made a high-level, public commitment to pursue delivery system reform in March 2013 (State of Tennessee, 2013) and worked to secure buy-in from key stakeholders throughout the planning process. The Governor's Office assigned the work of developing the Plan to the newly created Strategic Planning and Implementation Group in HCFA. A core team of three HCFA staff and five McKinsey staff were responsible for the process, though state staff from multiple divisions were involved in Plan development. Staff

from the Department of Benefits Administration, which oversees health plans for state and local government employees, participated in the payer and provider meetings, as well as a weekly executive management team meeting. Tennessee spent its entire \$756,000 Model Design award on contracted services (Tennessee Payment Reform Initiative, October 30, 2013). The state then supplemented the award with approximately \$4 million of state money, as noted, partially drawn from the state's hospital assessment trust fund, to fund the contract with McKinsey. State funding also supported the time state officials devoted to the Plan development process.

Stakeholder engagement. Tennessee engaged stakeholders through several separate, concurrent processes during the planning period. The state held four public roundtable meetings between June and September, which attracted a broad mix of stakeholders compared to Tennessee's other processes—including employers, providers, payers, and consumer advocates. These meetings typically included 50 to 70 participants, either in person or by teleconference. These 2-hour meetings were largely presentations by state officials and other experts (both within state and national), with time for comments and questions. Each roundtable addressed one of the following topics: proposed approaches to payment reform, health workforce, health IT, and population and behavioral health. Other stakeholder engagement activities included two webinars to engage employers and presentations to specific groups, such as medical specialty societies and a consumer advocacy group (Tennessee Payment Reform Initiative, December 9, 2013, Appendix A). Engagement with consumer representatives was not a strong focus of the state's Model Design process. Tennessee also posted its Draft Plan for public comment, leaving open this opportunity for over 1 month (the timing of the comment period prevented the the state from incorporating all the feedback in the version of the Plan it submitted to CMS as final).

Separately, Tennessee conducted a stakeholder engagement process for its Quality Improvement in Long-Term Services and Supports Initiative (QuILTSS), which informed the LTSS elements of the Plan. This process included 18 community forums statewide, with more than 1,400 participants. The engagement process was supported by the Robert Wood Johnson Foundation and led by TennCare and the Lipscomb University School of TransformAging (TennCare and Lipscomb University School of TranformAging, n.d.).

Work groups. Tennessee had stakeholder work groups that met regularly and were instrumental in the Plan development process. In addition, a Provider Stakeholder Group of physicians, primary care providers, nurses, hospitals, mental health providers, academic medical centers, and payers also met monthly. A Payer Coalition consisting of four payers (which cover among them all Medicaid managed care contracts, all state employee health plans, and the majority of commercial business), TennCare, and the state's Department of Benefits Administration leadership participated in these meetings and also met biweekly regarding the Initiative. Finally, three Technical Advisory Groups, each with 12 to 16 members—Tennessee clinicians nominated by provider associations, payers, and other stakeholders—met four to six

times from July to October to define the criteria for the three initial episodes of care. The state also held multiple one-on-one meetings with members of these groups, including payers, hospitals, and coalitions of providers. The state also reports having held three meetings with community groups.

Stakeholders engaged through the Provider Group, Payer Coalition, and Technical Advisory Groups generally approved of the level and frequency of contacts and the direction of the state's reform efforts, although they were not confident the Plan would reflect input from multiple sources. But the physicians and primary care providers, although represented by selected individuals on the Technical Advisory Groups, did not feel their constituencies were fully connected with the planning process. As one physician group explained: "The biggest negative is simply that most...[physicians]... just don't understand it. They are coming at it with a lot of pessimism but I think that will require salesmanship on our part. Most...[physicians]...are very happy with the status quo and don't want anything to change." Although the hospital stakeholders felt more engaged than physicians and were generally supportive of the Plan, they also expressed dissatisfaction with their level of input. Several had heard concerns about the Plan from individual hospitals or from the state's hospital association. The hospital association has engaged in an exchange of letters with the state, laying out its concerns around issues such as the lack of transparency around gain-sharing allocations. At the same time, state officials and payers described physician and hospital dissatisfaction as typical for Tennessee change initiatives. As one state official explained: "The reactions to change are not really entirely dissimilar to what we've seen on our other major change initiatives. It's always going to be a ground game, a lot of education, a lot of education and helping them to realize that some of their fears are for naught." A payer stakeholder speculated: "I think honestly, that's their [the providers] wanting to control the process more than they're able to."

Role of contractor. McKinsey was heavily involved in preparing and presenting materials and draft plans to stakeholder groups. It had previously worked closely with Arkansas on its episodes of care payment model and PCMH plan, and Tennessee had discussions with McKinsey prior to the Model Design award about the Arkansas models. Generally, stakeholders commented that McKinsey "clearly knew what they were talking about" and acknowledged many of the challenges to implementing the Arkansas model in Tennessee. However, one payer and two provider stakeholders expressed concerns about the way the state and McKinsey presented the model—feeling that the challenge of adapting the Arkansas model to fit Tennessee, given its large Medicaid managed care market and no dominant commercial insurer, was underestimated. Although these stakeholders appreciated having a forum to offer opinions on the evolving Plan, and said some of their feedback had been incorporated, they felt McKinsey and the state had already made major decisions and were not moved by their input. HCFA did, however, issue a memorandum in February 2014 announcing changes to the Plan to address concerns raised by stakeholders (State of Tennessee, 2014)

21.3 The Tennessee Plan

Tennessee's Plan is based on leveraging TennCare and Tennessee Benefits Administration (state health employee plans) contracts with health payers to introduce or expand three delivery and payment models. Implementation would begin with TennCare, two of the state's four managed care contractors for their state employee and commercial populations, and CoverKids (the state's Children's Health Insurance Program); as noted, the state anticipates the other commercial plans will then follow suit (Daverman, 2014). Of the Plan's elements, the episode-based payment model is most developed and said to be most likely to be implemented, though perhaps at a smaller scale, even in the absence of a Round 2 Model Test award. The Plan's PCMH strategy builds on efforts already started by payers; the Plan proposes to use a voluntary charter and state contracting to advance the PCMH strategy, particularly to reach smaller practices. A Round 2 Model Test award would support development of a multi-payer PCMH pilot. The state anticipates that the Plan's innovations will reach 80 percent of the state's population.

21.3.1 Models and Strategies

The Plan proposes three delivery and payment models: (1) retrospective payments for episodes of care, (2) expansion of PCMH models, and (3) value-based purchasing in LTSS. The Plan also describes enabling strategies in health IT, workforce, and population health, although these elements are not explicitly integrated into the three main models proposed (Tennessee Payment Reform Initiative, December 9, 2013). Our interviews with stakeholders focused on the first two models, because the LTSS strategy was developed in a separate stakeholder process and not formally incorporated into the state's Plan until after we had completed most interviews. [Appendix Table 21A-1](#) provides a summary description of the innovations proposed, initiatives on which they are built, populations they address, proposed policy levers, and supporting implementation entities.

Payment for episodes of care. This model is intended to improve quality and reduce unnecessary variation and average cost among providers for acute health care events through retrospective gain-sharing and risk-sharing. The Technical Advisory Groups convened by the state established parameters for three initial acute care episodes: (1) total hip or knee joint replacement, (2) hospitalization for severe asthma exacerbation, and (3) pregnancy-related services. Each episode has an identifiable start and end point, even though multiple providers (e.g., physicians, pharmacists, and hospitals) may provide care during the episode's course.

As proposed in the Plan, each episode identifies a principal accountable provider ("quarterback") best positioned to influence the quality of care and overall cost for the episode. For example, an orthopedic surgeon would be the quarterback for the joint replacement episode. The quarterback receives quarterly reports comparing the average overall cost for his episodes to

other quarterbacks' average overall costs. These reports also provide information on quality metrics. Providers who meet quality guidelines and have average costs that meet a threshold for "commendable" cost performance are eligible for gain-sharing (up to a maximum gain-sharing level, to discourage undertreatment). Similarly, providers that on average exceed an "acceptable" threshold are at risk for a portion of excess costs.

The draft Plan proposed that the first three episodes of care ("Wave 1") would have a test reporting period beginning January 2014 for TennCare MCOs, with the first paid performance period for Wave 1 running from July 2014 through June 2015. A February 2014 memorandum to providers indicates that this timeline will be delayed in order to incorporate episode design and methodology changes suggested by stakeholders. (State of Tennessee, February 20, 2014) Up to 75 episodes would be developed and implemented over the next 5 years. The episodes, as noted, would begin with TennCare MCOs, two payers implementing episodes for their state employee and commercial populations, and CoverKids. The state will continue to work with other payers and employers to voluntarily adopt this approach for commercial plans.

Patient-centered medical home. During the planning process, the state found that all major payers in the state were conducting PCMH activities. State stakeholders indicated they did not wish to displace these initiatives by mandating standard requirements for PCMH activities; but the state did obtain commitments from payers for a "charter on population-based models," through which the carriers agreed to "aspire for 80 percent of our members to be cared for by providers who participate in some form of a value-based contract, including but not limited to patient-centered, population-based, and integrated care models" (Tennessee Payment Reform Initiative, December 9, 2013, Appendix B). Should Tennessee be successful in securing a Round 2 Model Test award, the state proposes to require PCMH models of TennCare MCOs and to develop a multi-payer PCMH demonstration in one or two targeted regions of the state.

Long-term services and supports payment and delivery reforms. Tennessee's Plan contains three LTSS strategies with elements a Round 2 Model Test award would support. The QuILTSS initiative would restructure Medicaid nursing facility payments to include quality adjustment and other modifications. This is described as "prospective episodes." After a testing period, payments would begin in January 2016. Second, the state would modify QuILTSS to restructure Medicaid payments to home and community-based services providers. Finally, Tennessee would align Medicare and Medicaid benefits for full-benefit dually eligible beneficiaries by promoting voluntary enrollment in the same MCO for both Medicare and Medicaid, and adding requirements to Medicaid MCO contracts for coordination with Medicare.

The LTSS components were not formally included in the Plan (for example, LTSS was not mentioned in the white papers Tennessee released in August and November 2013, or in the monthly presentations made to providers) until the draft Plan was released in December 2013. State officials stated that the LTSS elements were present all along but working on a separate

track outside the SIM Initiative process. But stakeholders interviewed after the evaluation team was made aware of the LTSS components did not know about these elements of the Plan when asked. One payer said, in early December: “I haven’t heard about that last part [LTSS]. If that’s true, they have not disseminated that well.”

Health IT, workforce, and population health strategies. In addition to its major delivery and payment strategies, Tennessee considered health IT, workforce, and population health issues, although no strategies for these issues are developed specifically in the Plan. For health IT, Tennessee’s all-payer claims database currently has issues with the data in its system; however, the state has recently brought on a new vendor to improve system functioning and data quality. Tennessee also does not currently have a statewide capability for health information exchange, although some regional health information exchanges are operational. Tennessee plans to identify health IT needs and undergo a stakeholder process to design a solution to meet those needs. The Plan indicates that the state views its health workforce as generally sufficient, although some geographic areas are underresourced. The state would continue existing workforce programs (e.g., incentives for providers to practice in rural and underserved areas) and monitor workforce needs through a stakeholder process and available data. Tennessee plans to address population health through its existing public health programs, such as the Health and Wellness Taskforce and the Healthier Tennessee Initiative.

21.3.2 Policy Levers

Tennessee intends to rely on state executive branch and voluntary action to implement its Plan. Episode-based payments for acute care would be implemented through TennCare state contracts with Medicaid MCOs and contracts with payers for state employee health plans, and in the contractual arrangements between these payers and providers. The state does not currently anticipate needing to submit an amendment to its TennCare II Medicaid waiver for this purpose. The state is seeking voluntary action among commercial payers and self-insured employers to expand the use of an episode-based payment approach in alignment with the state’s approach. Likewise for PCMH, the state proposes to take executive branch action requiring PCMH in Medicaid MCOs and state employee health plans. The state has already secured voluntary action among commercial insurers to endorse a PCMH charter, and may further seek voluntary agreements to participate in a multi-payer PCMH pilot. LTSS policy levers would include changes to LTSS provider payments under Medicaid and consumer education to encourage coordination between Medicaid and Medicare MCOs. As one stakeholder expressed it, the state is also holding the potential Medicaid expansion under negotiation as a lever for creating and expanding payment reforms. Its rationale is that, after a Medicaid expansion, more providers and possibly payers will be involved with more people covered—resulting in a greater interest in potential cost savings from reforms. Additional detail on policy levers is included in [Appendix Table 21A-1](#).

The state did not consider strategies that would require legislative action, such as placing requirements on commercial insurers. Nor did the state place regulatory requirements on insurers, because the state perceives this as hindering constructive stakeholder engagement (Tennessee Payment Reform Initiative, December 9, 2013).

21.3.3 Intended Impact of the Plan

Stakeholders indicated that the innovations being considered were likely to reach 80 percent of the state's population, and the state makes this prediction in the Plan itself. The Plan emphasizes the PCMH approach as being particularly important to reaching a preponderance of the state's population, although the state expects the strategy for implementing 75 episodes of care in 5 years would also contribute to reaching the 80 percent goal. The LTSS strategies would affect the population already using Medicaid LTSS services. The Plan is intended to improve quality and coordination and reduce variation among providers and is expected to have positive effects for individuals with chronic health conditions. Across all three strategies, the state projects a cost avoidance of \$1.1 billion over 3 years, which would accrue to Medicaid, Medicare, and commercial and out-of-pocket spending (Tennessee Payment Reform Initiative, December 9, 2013).

21.3.4 Proposed Next Steps

Tennessee will pursue a Round 2 Model Test award to support most of the Plan's implementation. TennCare has already started implementing the episode-based payment model—MCOs are currently writing language into their provider contracts for the three Wave 1 episodes of care to start in 2014, with development and implementation of additional waves of episodes set to occur in 2015 and 2016. The state employee health plan is planning to implement the episode-based payment model at the same time as TennCare, although that agency faces additional complexity in its contracting process as compared to TennCare.

21.4 Discussion

Tennessee's planning process generated support for the concepts of episode-based payments and PCMH among participating stakeholders, including payers, hospitals, and health infrastructure organizations. The decision to tackle technical details from the outset meant that stakeholders saw implementation of the initial episode-based payment as highly likely, and the state has already begun implementation. For Tennessee to implement these models successfully, however, continued buy-in of hospitals and physicians would be a major factor—both of which have a strong influence on implementation because of managed care contracting. The state has secured providers' general support for the Plan, though work continues on some details; and state officials are quite optimistic about the success of the process and the promise of Plan implementation.

21.4.1 Critical Factors Shaping the Plan

Perceptions of the Plan and the process the state used to develop it vary widely depending on the stakeholder. At the time of our interviews, state officials were satisfied that the process had gone well, with the right level of staffing, the right leadership, and the right stakeholders. As one state official commented: “In my entire tenure with the state, I don’t think we have ever engaged in a more inclusive stakeholder process, and one that truly was about design.” However, multiple provider groups expressed dissatisfaction that they were not engaged enough, and nearly all stakeholders saw the possibility of provider objection as the biggest risk to the Plan’s implementation. The critical factors behind these divergent perceptions may include previous relationships among stakeholders, perceptions of the cost containment aspects of the Initiative, and the planning process itself—adding up to a focus on the implementation details of episodes of care.

The overarching transformation strategy of episode-based payments and PCMH was based on similar activities in Arkansas. Prior to the SIM Initiative, TennCare put forth this basic framework during its participation in the hospital association’s Vision Taskforce, after various stakeholders voiced their concerns with the current delivery system and criteria for a new model of care delivery. A TennCare official explained: “We had to pick a path because otherwise continuing to talk about a theory wasn’t going to get us anywhere. So based on all that consideration and feedback, we took the path that we believed addressed the issues that were raised.” The Arkansas model was attractive to Tennessee, because it had value-based payment while taking some burden of change off providers with limited capacity by using retroactive payments that put the bulk of the work on payers. Several consumer stakeholders said they believed cost containment was a primary driver for Tennessee’s past health reform efforts and for the Plan. State officials noted that the episode-based payment models and PCMH strategies in the Plan were important, because they incentivized providers to improve quality while helping the state achieve sustainable spending trends.

21.4.2 Lessons Learned

Tennessee’s experience with the SIM Model Design yields several lessons, according to stakeholders.

- **Stakeholder engagement depended on expertise of the stakeholder.** Because Tennessee’s process focused on technical discussions, stakeholders observed that those with the strongest existing expertise had the most influence. Although the choice to move quickly to details gave the process momentum, in a state where existing expertise was limited to a few groups, additional education may have been warranted to facilitate broad participation in Plan development.
- **Developing an episode-based payment approach is highly complicated and requires new expertise.** Even for those stakeholders with relevant expertise, such as

payers, developing the three initial episodes was a new process, and was more difficult technically than they expected. For example, at first the Technical Advisory Groups had difficulty responding to questions about risk adjustment and reporting methodologies, and they needed additional guidance from consultants to be able to provide feedback. As a result of working through the technical details beneath the framework, the state and its stakeholders are now more aware of what it will take to implement and expand this model, because they had to grapple with the details of episode design.

- **Previous relationships had a strong effect on perceptions of the Plan.** This process was more inclusive than any Tennessee has undergone recently, and stakeholders perceived TennCare as highly competent in executing initiatives. Still, stakeholder reactions fell largely in line with reactions to previous initiatives: some providers expressed dissatisfaction with their level of input into the plan, payers saw HCFA as driving most decisions, and consumer groups perceived the state’s primary goal as reducing spending. Just bringing stakeholders into the Plan development process did not fully address these lingering perceptions.
- **Adapting to evolving CMS requests was challenging once the design process had started.** Tennessee’s approved SIM Model Design award proposal was titled “Integrating Value-based Purchasing into the Managed Care Model” and included only TennCare as a payer. Throughout the planning process, state officials became aware of CMS’s more far-reaching goals for the Initiative—for example, when they read through quarterly report requirements to describe work to advance population health, health IT, and health care workforce development. With the state’s resources and planning process already focused on the episode-based payment model and PCMH, state staff and external stakeholders (even those with population health, health IT, or workforce expertise) grappled with how to fit these other elements into the state’s payment reform strategy as laid out in its original Model Design award proposal. Thus, population health, health IT, and workforce are less fleshed out than other aspects of Tennessee’s plan.

21.4.3 Potential for Implementation

Episode-based payment has already begun to be implemented in Tennessee. The first three episodes of care were developed during the planning process and are to be implemented whether or not the state receives a Round 2 Model Test award. State officials also believe additional episodes could be implemented, although they worry the process would lose momentum without a Round 2 Model Test award, because of the high staffing and technological infrastructure needed to develop and execute this model for a large number of care episodes through a similar stakeholder process. State, hospitals, and payer stakeholders all believed that the initial implementation would indeed go forward in TennCare and that the test period would be helpful for both providers and plans to feel comfortable with the model. Stakeholders had mixed perceptions of whether the first three episodes would be implemented in the state employee health plan and commercial markets by summer 2014, as planned. Given that it took 9

months to develop the first three episodes, stakeholders questioned the feasibility of quickly developing up to 75 additional episodes in 5 years. The Plan proposes to ramp up implementation of episodes through several strategies—including having a single Technical Advisory Group advise on the development of multiple episodes, and by leveraging episodes developed in other venues, such as CMS’ Bundled Payments for Care Improvement Initiative.

The state has the ability to introduce PCMH charter elements into TennCare and the state employee health plan without a Round 2 Model Test award; but implementation of a PCMH multi-payer demonstration is contingent on receipt of the award, as would implementation of LTSS reforms in the state’s Plan. Interviewees did not provide a clear sense of whether they believed the PCMH and LTSS aspects of the Plan to be feasible. Payers seemed reluctant to standardize aspects of their PCMH programs. Although they saw the value of reducing provider reporting burdens and aligning incentives, all payers saw a risk that innovation would be stifled. A PCMH charter was released after our interviews, which may indicate the state was able to overcome some of the payers’ reluctance.

The state, payers, and hospital and physician groups all see resistance from hospitals and providers as the biggest risk to implementation. Though providers approved of the overarching framework, they expressed some dissatisfaction with their level of engagement in the planning process and with some of the Plan’s details. For example, several providers did not agree with some of the adaptations the state made to the Arkansas model for episode-based payment to fit Tennessee’s managed care environment (e.g., the Plan proposed that each MCO or insurance carrier would set its own thresholds for “commendable” performance, and each plan would conduct its own risk adjustment, rather than these being set by the state as in Arkansas). Since publication of the Plan, a February 2014 memorandum to providers outlined changes the state was making to respond to stakeholder feedback—including efforts to seek alignment among MCOs around risk and gain-sharing and to increase transparency on risk adjustment by MCOs.

Hospital engagement would be particularly important in Tennessee, because in TennCare MCOs must negotiate contracts with individual providers. As one payer explained: “I like the actual model. Only downside is, it’s not the model per se, it’s if providers revolted against it. Because there will be a moment next year where every carrier has to go out and get providers to agree to it.” Tennessee has a few key regional hospitals and health systems that MCOs and commercial plans must have in their networks to be viable, so these providers have significant leverage in contracting with payers in their region. Still, at the time of the interviews, hospitals had not taken any significant steps against the Plan. Additionally, while the payers involved in Plan development represent a large majority of the covered lives in the state, payers expressed some concern that not all commercial insurers would participate—giving providers additional leverage if they have the option to join the network of an insurance carrier that is seeking to grow its presence in the Tennessee market but is not participating in the state’s model.

Other risks a few stakeholders identified included the possibility of the MCOs and commercial insurers not carrying out the Plan in good faith. As one stakeholder who works with providers and payers stated: “I think they need to be very careful about how they navigate these ‘deals’ with the health plans.” An additional risk, identified especially by carriers, was the intensive reporting and measurement that would be required to determine payments. As one payer explained: “the Achilles [heel] to this methodology is that it’s extremely labor intensive.” As noted above, the state has plans to enhance data systems where needed (such as improvements to the all-payer claims database and capacity for health information exchange), and anticipates that reporting and analysis would become less burdensome after an initial development period.

21.4.4 Applicability to Other States

Though it is adapted from Arkansas’ model, the Plan is innovative because the dynamics of implementing this type of model are very different in Tennessee than in Arkansas’ fee-for-service environment. Tennessee is likely the first state with Medicaid managed care and a competitive insurance market with no dominant insurer to work through both the process of developing episodes themselves and the corresponding methodology. Tennessee’s experiences may be instructive to states with similar insurance markets. Some aspects of Tennessee’s market are unique, particularly the Medicaid program (e.g., CHOICES), and resulting regulations and laws in Tennessee may influence particular details of the Plan (such as regulations about provider networks for managed care), according to stakeholders. In addition, Tennessee’s process of selecting a model and quickly moving to work through the details with stakeholders holds lessons for all states, including those embarking on a planning process and those that have already planned to implement episode-based payments but have not begun the detailed work.

21.4.5 Limitations of This Evaluation

A major limitation of this analysis is lack of LTSS stakeholder perspectives. Our evaluation team was not made aware of the LTSS components to the Plan until late November 2013. At that point, an LTSS question was inserted into the remaining scheduled interviews with stakeholders, but LTSS-specific interviews were not scheduled. The state did not include any LTSS-specific stakeholders in the list of recommended interviewees it provided to the evaluation team, and its driver diagram did not include an LTSS component. Other perspectives not well represented in our interviews include state employees as consumers and primary care providers. These interviews were not scheduled because of lack of response or scheduling difficulties. A final limitation is that, because the PCMH Plan details (including development of the PCMH charter) were largely fleshed out during November and December 2013, after our interviews were conducted, the analysis may not reflect the full extent of the PCMH work Tennessee undertook. The state has continued to refine the Plan in early 2014; we have reflected some of

these adjustments in this report; but stakeholder interviews were conducted before those adjustments, so we do not have information about how stakeholders view these changes.

21.5 References

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Appendix Table 21A-1. Models and strategies proposed in the Tennessee Health Care Innovation Plan

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|---|---|---|--|---|
| <p>Payment for episodes of care Retrospective payment for episodes of care with a principal accountable provider, beginning with three initial episodes (Wave 1) and increasing to 75 within 5 years.</p> | <p>Model is based on Arkansas’ approach to episodes of payment, modified for Tennessee’s managed care environment</p> | <p>Patients with acute health care needs covered by TennCare (Medicaid), the Tennessee Benefits Administration (state employees), and commercially insured patients</p> | <p>Existing TennCare contracts with MCOs modified to implement episodes defined in Wave 1 Proposed executive branch action Implement additional episodes in Medicaid MCO contracts Implement Wave 1 episodes in contracts for state employees’ contracts Proposed federal action *Round 2 Model Test Award Proposed voluntary actions Implement episode-based payments in commercial plans</p> | <p>Providers (mostly acute care), TennCare, Tennessee Benefits Administration, potentially commercial insurance plans and employers</p> |
| <p>Patient-centered medical home PCMH Charter across payers to bring initiatives into alignment Implement a multi-payer PCMH demonstration in one or two regions Require Medicaid MCOs to align on a PCMH strategy with learning collaboratives, transition a percentage of Medicaid patients into PCMHs Potential for similar strategy with state employees’ health plans</p> | <p>All major commercial carriers in the state have existing PCMH programs</p> | <p>Statewide insured/Medicaid population (for PCMH alignment); estimated 200,000 patients in one to two regions where multi-payer PCMH demonstration is implemented; Medicaid and state employees for PCMH requirement in those respective programs</p> | <p>Existing Commercial payers endorsed PCMH charter Proposed executive branch action Require PCMH in TennCare and state employees’ health plan contracts Proposed federal action *Round 2 Model Test award Proposed voluntary action Participate in multi-payer PCMH demonstration</p> | <p>Primary care providers, TennCare and Tennessee Benefits Administration, Medicaid MCOs and commercial insurance plans</p> |

(continued)

Appendix Table 21A-1. Models and strategies proposed in the Tennessee Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|---|---|--|---|--|
| <p>Long-term services and supports payment and delivery reforms QUILTSS restructures prospective nursing facility payments to include a quality adjustment and other modifications</p> | <p>CHOICES program, which passed in 2008, promoted home and community-based services in Medicaid, and redesigned LTSS payments. A federal money-follows-the-person grant funded part of this work</p> | <p>Elderly and physically disabled adult Medicaid beneficiaries using LTSS</p> | <p>Proposed executive branch action Redesigning Medicaid payments to LTSS facilities and home and community-based organizations Add requirements for coordination to MCO contracts for dually eligible beneficiaries Consumer education to encourage enrollment in the same MCO for Medicaid and Medicare dually eligible beneficiaries</p> | <p>LTSS providers including nursing facilities and home and community-based services providers; TennCare; Medicaid and Medicare MCOs</p> |
| <p>Adapt QUILTSS methodology for payment to home and community-based services Aligning Medicare and Medicaid benefits for full-benefit dually eligible beneficiaries, by promoting enrollment in same MCO for both Medicare and Medicaid</p> | <p>Tennessee also undertook extensive planning for the federal Duals demonstration but withdrew its participation in late 2012</p> | | <p>Proposed federal action *Round 2 Model Test Award</p> | |

(continued)

Appendix Table 21A-1. Models and strategies proposed in the Tennessee Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|--|---|-----------------------|---|---|
| Health information technology Identify health IT needs, evaluate gaps, create a stakeholder process to design a solution to meet health IT needs and expand health IT use | Directed Exchange: Pilot through state Office of eHealth Initiatives to roll out direct secure messaging CMS' Medicare and Medicaid EHR Incentive Program Tennessee Regional Extension Center works with providers to adopt health IT and EHRs | N/A | Existing Continue EHR incentive program to support providers in direct messaging for care improvement Proposed executive branch action Identify needs, gaps, and solutions through unspecified stakeholder process | Office of e-Health Initiatives, various stakeholders (providers, payers, employers, Medicaid, Medicare) |
| Population health Tennessee plans to address population health and social determinants of health through its existing programs Plan does not indicate a robust connection between population health activities and three main strategies of episodes of care, PCMH, or LTSS | Plan mentions various state initiatives, including Health and Wellness Taskforce, Healthier Tennessee Initiative, and Healthy Memphis Common Table | General population | Existing programs will continue functioning | N/A. Programs are already implemented |

(continued)

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Appendix Table 21A-1. Models and strategies proposed in the Tennessee Health Care Innovation Plan (continued)

¹Policy levers include Medicaid waivers; federal grants (including Round 2 SIM award); state laws; state regulations; state investments (e.g., in public health programming); foundation grants; employer-led coalitions to drive change among providers, purchasers, or plans; state government–led coalitions, task forces, or commissions to drive voluntary change among providers, purchasers, or plans; state purchasing contracts; and state-level (Governor-initiated) executive policy directives.

Abbreviations: EHR = electronic health record, GME = Graduate Medical Education, IT = information technology, LTSS = long-term services and supports, MCO = managed care organization, N/A = not applicable, PCMH = patient-centered medical home, QulLTSS = Quality Improvement in LTSS Initiative, SIM= State Innovation Model.

22. Texas

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The Texas Health and Human Services Commission (HHSC)—with support from its contractors, Health Management Associates (HMA) and Deloitte Consulting LLP—led development of Texas’ Health Care Innovation Plan (the Plan). Perhaps the most important part of the state’s context is the strong regional and local health care system in the state, which necessitates building on the current health care infrastructure within each region. Given the need to develop the Plan in a way that would be acceptable to stakeholders across the diverse communities in Texas, HHSC convened stakeholder meetings in every region of the state, with all stakeholder groups participating. However, multiple stakeholders, including payers, health plans and providers, noted the lack of infrastructure available for ongoing engagement in the planning process. Ultimately, one-on-one meetings near the end of the planning process between stakeholders and HHSC and HMA staff helped to finalize the Plan.

The Plan’s vision is to build clinical transformation through several steps, prominently including expansion of medical and health home models, given the requirement that the Plan reach 80 percent of the state population. The Plan builds off existing and emerging public and private efforts, including a significant investment in health information technology (health IT) across the state, the state’s 2011 Medicaid section 1115 demonstration waiver, the Bridges to Excellence (BTE) program used by Blue Cross Blue Shield of Texas for commercial populations with chronic health conditions, and various initiatives in the state focused on diabetes.

A major goal of the Plan is to provide support to leverage learning from the wide range of initiatives already under way across the state: disseminating information on best practices and evidence-based programs and promoting multi-payer collaboration. This is in line with the Plan’s primary reliance on voluntary collaboration by payers, health plans, and providers. The Plan also expects substantial variation to remain, as best suits local and regional circumstances. A SIM Council would be created, under the auspices of the newly created independent Texas Institute of Health Care Quality and Efficiency (TIHCQE), to carry out Plan implementation. But there is, as yet, little information on specific changes or key players that would be needed to effect the changes.

22.1 Context for Health Care Innovation

The Plan, which represents the first statewide discussion of health care system reform, began as an effort to develop a common understanding and consensus around health care delivery system transformation in the state that builds off existing and emerging efforts at system

change. At the time the SIM Initiative started, a wide array of state, regional, and local efforts were already under way in the state, organized by payers (notably Blue Cross Blue Shield of Texas and Medicaid) and regional and local health care system providers. These efforts include delivery, quality, and purchasing initiatives, and the state's recent investments in health IT and electronic health records (EHRs) with federal funding through CMS' EHR Incentive Program and other sources (Palmer, 2013). HHSC's goal was to develop a plan that built off those existing and emerging initiatives, using them as the foundation for broader system change.

Important to development of the Plan is the strong regional and local health care system in the state. Many stakeholders noted that any reform efforts would need to build on the current health care infrastructure within each region, working with the current status of providers in the region in terms of medical homes, health IT, and current innovations that are under way or developing to move toward system transformation. Stakeholder consensus was strong that a one-size-fits-all, top-down model of system transformation would not work in Texas.

Blue Cross Blue Shield of Texas has been using the BTE program, a quality measurement and payment incentive program for patients with chronic conditions maintained by the Health Care Incentives Improvement Institute (Hood et al., 2013). By building on a successful commercial initiative to provide care coordination for persons with chronic conditions, and on several existing statewide efforts to improve care for persons with diabetes, expanding on the BTE initiative is seen as a strategy with a high probability of success and, thus, replication for other chronic conditions and populations. Additionally, several commercial health plans (not identified because of concerns about market competition) provide incentives for providers achieving PCMH certification and many clinicians are already recognized (HMA, 2013b).

The current Medicaid program also provided important context for the Plan. Senate Bill 7, 82nd Legislature, First Called Session, 2011 authorized an outcomes-based payment strategy for Medicaid aimed at reducing: (1) potentially preventable hospital admissions, (2) potentially preventable hospital readmissions, and (3) potentially preventable emergency department visits. The state's Medicaid section 1115 demonstration waiver, called the Texas Health Care Transformation and Quality Improvement program, allows the state to expand Medicaid managed care and creates new funding methods for supplemental Medicaid payments to providers under an Uncompensated Care Pool and Delivery System Reform Incentive Payment (DSRIP) projects (HHSC, 2013a). More than 1,300 DSRIP projects across all regions of the state support provider-directed strategies to change local health care systems, using a range of health care transformation models (HHSC, 2013b).

Finally, aspects of Texans' current health status identified as needing improvement also shaped the Plan. Specific areas of concern included diabetes care and outcomes, high rates of pre-term births, as noted, and poor rates of self-reported health status (HMA, 2013c).

22.2 Planning Infrastructure and Process

Between the application for the SIM Model Design award and the start of the planning period, leadership at HHSC changed significantly, including retirement of the major advocate for the state's SIM effort. Although HHSC executive staff continued to receive updates on development of the SIM Initiative, due to competing priorities at HHSC as the planning process began, HHSC relied heavily on HMA to coordinate the planning process.

The size and diversity of the state, along with the strong regional and local focus in health care delivery, were also challenges for the planning process. Although efforts were made to engage a wide range of stakeholders through regional meetings, multiple stakeholders, including payers, health plans and providers, suggested the lack of infrastructure for ongoing engagement, and the initial absence of concrete elements of the Plan that stakeholders could react to, limited this process. Ultimately, one-on-one meetings near the end of the planning process with a few stakeholders (including payers, health plans, and providers) and with the Texas Institute of Health Care Quality and Efficiency (TIHCQE)—a new independent organization created by legislation in 2011 to improve care delivery in the state—proved the most fruitful in developing areas of the Plan that built on existing initiatives and organizations. In addition, this effort to engage so many stakeholders enabled many to learn about a number of existing and emerging initiatives in Texas they had not known about before.

Governance and management. The Medicaid office in the HHSC led the planning process, because of the Medicaid director's keen interest at the time in pursuing a Model Design award. However, this Medicaid director retired before the planning process began, as noted, removing his strong advocacy of the initiative within the state agency. Subsequently, responsibility for the Plan became one of a number of other competing priorities for HHSC staff assigned to the project, since the planning period coincided with the state's legislative session. As a result, HMA, the consultants hired to assist HHSC with the planning process, led the substantive work of stakeholder engagement and Plan design. Although a number of stakeholders noted that the initiative appeared to lack a high-level champion within the state government, and perceived only limited involvement of executive-level staff in developing Plan details, executive-level staff was briefed throughout the planning process and reviewed and approved the final Plan. The current Medicaid director at HHSC was also involved in discussions regarding the SIM Initiative and participated in the statewide conference that proved critical in developing the Plan (see conference description below). Other than the in-kind support of these state officials and the SIM Model Design award, the state invested no additional resources in the planning process.

Stakeholders generally spoke highly of the efforts of HMA and the HHSC staff involved in the planning process. However, there was a sense among stakeholders representing payers,

health plans, and providers that the state Medicaid agency may not have been the best convener for this effort—both because, as a large and complex state agency, it is viewed as highly bureaucratic and because it may lack influence among a multi-payer audience. In response to this perception, both HHSC and representatives of TIHCQE suggested that TIHCQE might be better suited to leading this type of effort in the future. TIHCQE is an independent, statewide organization that includes representation from multiple payers on its board of directors and is supported by staff from HHSC (TIHCQE, 2013). Created by legislative mandate in 2011 to improve the health care system in Texas, TIHCQE was brand new when the SIM Initiative planning process began and therefore did not play an active role in Plan development until late summer. TIHCQE will provide leadership for the Initiative should the state decide to pursue the Plan. Specifically, a SIM Council would be created, under the auspices of TIHCQE, to carry out the Plan.

Stakeholder engagement. Stakeholders were engaged in development of the Plan through emails, Webinars, regional meetings, and a statewide conference. In addition, HHSC and HMA conducted one-on-one meetings following the regional meetings and statewide conference to gather more information from health plans, provider associations, and TIHCQE. Stakeholders were largely informed about the Webinars, regional meetings, and statewide conference through an email list compiled by HHSC. Materials from meetings and Webinars were made available on the Web site (HHSC, 2013c).

In general, a broad range of stakeholders participated in the regional meetings—including public and private payers; Medicaid and commercial health plans; providers (e.g., physicians, nurses, dentists, behavioral health providers, public health providers), and provider associations; administrators from physicians and dental practices, clinics, hospitals, and health systems; and administrators from local mental health authorities and local public health departments. Some stakeholders noted that HHSC has used this style of outreach for other initiatives, although they saw less value from having been brought to the table to participate in this planning process. A general sense among many stakeholders was that there was little depth to the discussions, so that the hard conversations about how to actually change the state’s health care system have yet to occur.

Although there was broad participation in the planning process, a number of stakeholders were viewed as missing from the process entirely or, though present, not actively engaged. Largely missing were consumers and consumer groups, which were viewed by other stakeholders as playing a minor role in the health care system in Texas. Further, a range of stakeholders—including some from HHSC, health plans, and provider groups—perceived that health plans, employers, payers, and state agencies were not fully engaged in the planning process, as they were often present for meetings but not active participants in the discussions. Some stakeholders who did not engage actively in the process noted that they were too busy with

other issues, including the legislative session, or that they were monitoring the process to see in what direction the Plan would go before investing significant amounts of time.

Regional meetings. In starting the planning, HHSC began with a clean slate in terms of the Plan's proposed models and strategies, allowing details to emerge from input given at the 14 regional meetings held to engage stakeholders around the state. At the regional meetings, HMA staff made presentations on the general philosophy of the Initiative and potential strategies, with few details on specific design elements. Stakeholders were invited to give recommendations on the broad direction of the Plan by commenting at these meetings, follow-up after the meetings, and through a stakeholder survey. Although certain themes were recurrent in stakeholder feedback (such as general support for PCMHs, the need for additional investment in health IT and EHR implementation, and helping providers move toward accountable care organizations [ACOs] [HMA, 2013a]), several stakeholders suggested it would have been helpful to start with a more developed straw man model for the Plan that would have allowed for more concrete discussions.

Stakeholder surveys. The HHSC/HMA surveys of stakeholders included an online survey in June 2013 and a "real-time" survey as part of the August conference. Survey responses were obtained from stakeholders across the state, including public and private payers, health plans, providers, trade associations, community-based organizations, and consumer organizations. The survey focused on stakeholder interest in different types of innovation models (medical homes, shared savings models, ACOs), and specific elements of different types of innovation models (e.g., behavioral and physical health integration, long-term care services).

Ongoing stakeholder engagement. Lack of infrastructure for ongoing involvement in the planning, such as through work groups or committees, made it difficult for stakeholders to remain engaged throughout the planning process. This proved to be a source of frustration for several stakeholders (including representatives of health plans and providers), because they felt there was little opportunity to work through the specifics of how to make changes to the Texas health care system. Furthermore, lack of clarity on whether the state would move forward with the Plan made it difficult for many stakeholders to invest significant amounts of time and resources in the planning processes. Certain stakeholders, such as payers and health plans, were also engaged in the process through one-on-one meetings with HHSC and HMA, given competitive concerns that constrained some payers and plans from being candid at public meetings.

Statewide conference and follow-up. A turning point in stakeholder engagement occurred at the statewide conference in August, which was viewed by many as an important convening of key stakeholders (HHSC, 2013d). It was noted by multiple stakeholders, including representatives from state agencies, health plans, and providers, that this conference was one of the first times such a broad range of stakeholders had come together in the state; and that it

generated additional energy among key stakeholders who helped add more specificity to the Plan in one-on-one meetings following the conference. In addition, the role of TIHCQE in the planning process expanded after the statewide conference, including a potential leadership role for future Plan implementation. Although HHSC and HMA had attempted to engage TIHCQE for this role before the conference, it was at the conference that members of the TIHCQE board recognized the SIM Initiative as a good fit for their organizational goals. Nonetheless, a number of stakeholders noted that they did not hear anything else on the progress of the Plan after the conference—leaving a strong impression that, despite the multiple meetings held to convene stakeholders, the Plan was ultimately driven by HHSC, with little opportunity for stakeholders to contribute to the specifics of its design.

22.3 The Texas Plan

The conceptual model for health care innovation underlying the Plan is the goal of promoting better health by providing better care at lower costs. The drivers of health care innovation in the state are: (1) healthy lifestyles, (2) expanded patient and family engagement and accountability, (3) increased use of evidence-based screening and appropriate care, and (4) coordinated and clinically integrated care. To support those efforts, the Plan would leverage the learning from the wide range of initiatives under way and being developed in the state, in both public and private sectors (State of Texas, 2014).

22.3.1 Models and Strategies

The Plan includes five major components intended to set forth a vision for an integrated strategy to build and sustain clinical care transformation in the state: (1) clinical care transformation programs, including PCMHs and chronic disease management; (2) supporting multi-payer engagement and alignment to support clinical care transformation; (3) expanding community-based public health innovations; (4) health IT, EHR, and HIE expansion and sustainability initiatives; and (5) spreading and sustaining best practices and innovations for clinical care transformation. *Appendix Table 22A-1* provides a summary description of the Plan. Much of it is still at a very high level, with work needed to sketch out the specifics of the changes that would be needed for implementation and the key players that would lead those transformation efforts.

The requirement that the payment and delivery system changes in the Plan reach at least 80 percent of the Texas population led to the focus on expanding medical and health home models, as a change that could have a positive influence across the continuum of care for all Texans. Health IT and EHR implementation was viewed by stakeholders as critical to development of models of patient-centered care; thus, expanding and sustaining EHR adoption and meaningful use is an important Plan component.

The specific strategies and innovations proposed in the Plan are intended to build on and leverage current innovations under way or developing in Texas, with the expectation that there will be substantial variation across the local and regional areas in the Plan components considered most relevant to their current circumstances. The Plan emphasizes the diversity of the health care markets across the state, with the expectation that there will be significant differences in urban and rural areas, by region, and across practices and health care systems. The Plan aims for multi-payer collaboration and overall alignment of value-based payment models—through dissemination of best practices, spreading of community-based and evidence-driven programs, and removal of administrative and legislative barriers to payment reform in the state.

Medical, health, and maternity homes and chronic disease management. There is strong interest in medical, health, and maternity home models in Texas but, with many physician practices in Texas being relatively small, there is often little administrative or financial capacity to support moving toward those models of care. A key goal of the Plan is to meet providers where they are in the continuum of clinical care transformation and help them move further toward medical and health home models. Texas has outlined three key models of clinical care transformation that would be encouraged under the Plan: PCMHs, health homes, and maternity homes, all of which are collectively referred to as “medical homes” in the Plan and build on initiatives under way in the state. First, the Plan proposes a Medical Home Training Program, which would target small and medium-sized practices that do not yet have National Committee for Quality Assurance (NCQA) recognition. The Plan also proposes that health plans support (financially and with technical assistance) provider participation in NCQA PCMH recognition through a Medical Home Recognition Program. This would be modeled on the Health Resources and Services Administration’s current Patient-Centered Medical/Health Home initiative. Finally, Texas would expand the BTE Care Recognition program to Medicaid managed care. According to interviewees and the Plan, the BTE Care Recognition program has been successful at improving care and reducing costs for persons with chronic diseases in commercial markets. This new Chronic Disease Care Recognition Program would provide technical assistance and cover costs for providers to obtain BTE care recognition in diabetes, hypertension, depression, and potentially other conditions, and would include an annual payment per patient diagnosed with these conditions. BTE is viewed as an interim step in helping practices move toward medical and health homes.

Multi-payer engagement and alignment. To support and sustain changes in health care delivery under the Plan, Texas is proposing several strategies to support developing multi-payer collaborations, with a focus on persons with chronic conditions and pregnant women. These include: (1) building on nationally recognized programs and fostering discussions to develop public-private initiatives around delivery system transformation to address quality-based care across the regions in the state; (2) exploring strategies to align Medicaid, Medicare, and commercial payers in diabetes care and prevention; and (3) exploring the feasibility of creating a

multi-payer data warehouse and reporting system in the state. Differences in corporate culture, product lines, and population demographics across the state are perceived to make multi-payer collaboration difficult.

Public health strategies. One of the goals of the Texas Plan is to expand opportunities for better health decisions by supporting adoption of healthy diet and fitness practices, better care for chronic conditions, and reduced risk for pre-term births. A key component here is a Public Health-Medicaid Managed Care Diabetes Education Project, which would build on successful efforts by the Texas Diabetes Council to improve diabetes self-management in Medicaid. The state would also expand on the National Diabetes Prevention Program (DPP), which is already operating in Texas with multi-payer support, to prevent the onset of diabetes in those diagnosed with prediabetes among the population in Medicaid and, potentially, the Texas Employee Retirement System.

Health IT. The Plan has several strategies designed to strengthen health IT throughout the health care system in the state. The Plan proposes that Medicaid's health IT office develop a plan to support providers excluded from participation in the federal EHR Incentive Program. This health IT plan would leverage the existing infrastructure used for the EHR Incentive Program, for example, by expanding the technical assistance available through the four Regional Extension Centers in Texas for EHR selection and adoption to small, rural, and behavioral health and long-term care services and supports (LTSS) providers. In addition, the Plan aims to encourage expansion of HIE participation through greater provider education and awareness, including developing a use case for building capacity for acute care hospitals and outpatient settings to exchange admission, discharge, and transfer notifications with the goal of reducing hospital readmissions. The lessons learned in a pilot test of the use case would then be incorporated into a learning collaborative that has been proposed through the state's Medicaid section 1115 waiver, with the expectation that the findings would build community support for HIE participation among providers and payers. Finally, the Plan would support initiatives aimed at HIE sustainability, primarily through incentives for expanded public and private payer participation. Texas currently has an HIE managed by the Texas Health Services Authority that connects local HIEs and health information service providers. The Plan proposes three strategies to boost payer participation in this program (including Medicaid and the Children's Health Insurance Program [CHIP], Medicare, county and state-run programs, and commercial insurance): payer-sponsored payments to providers for HIE utilization, payer-sponsored payments to certified HIEs for connecting providers, and provider incentives to report quality measures to Medicaid.

Spreading and sustaining best practices. A key component of the Plan is to support the spread of best practices in clinical care transformation in the state, especially as it relates to Medicaid managed care. This would include developing a learning collaborative housed within

TIHCQE to teach best practices and provide in-person teaching and technical support (the Health Innovation Learning Network)—providing dedicated staff to support the implementation of strategies to improve care delivery across the state (especially in Medicaid and CHIP), and developing an online database of health care innovation activities in the state to support the sharing of information on promising strategies.

Other strategies discussed but not included in the Plan. Because a key component of the stakeholder convening was to allow stakeholders from across the state to provide input into potential strategies for system transformation, a wide variety of additional topics were considered in the planning process. These included ACOs, shared savings arrangements, bundled or episodic payments, strategies to address workforce capacity (including telemedicine) and workforce training, models to increase patient engagement and accountability, aligning standards and reporting requirements under the various state regulatory authorities, standardizing administrative and quality reporting requirements across health plans and Medicaid, standardizing the approach to payment for care coordination activities across payers, integrating the delivery of public health services and community-based prevention strategies in health system redesign, integrating behavioral and physical health, expanding LTSS services, developing common reimbursement strategies for LTSS, implementing quality-based payments for LTSS providers, and improving early childhood and adolescent health. As noted in the Plan, some of these were dismissed by HHSC and HMA as not consistent with the objectives of the project, too limited in scope, or duplicative of other efforts under way in the state. Others, although supported by some stakeholders, were not supported broadly enough by stakeholders across the state to be included in the final Plan. For example, payers expressed more interest in bundled payment arrangements than did providers. Finally, some topics, like efforts to improve the workforce, were judged beyond the scope of the SIM Initiative funding and time frame.

22.3.2 Policy Levers

The Plan, as noted, is intended to leverage core initiatives under way and being developed in the state. However, the state context limits the potential policy levers that could be used for a more state-driven approach—relying instead on voluntary collaboration by payers, health plans, and providers. By aligning with existing initiatives, the Plan sets forth a vision for how existing efforts could come together as an integrated strategy for system change. Most of those whose cooperation would be required have yet to commit to implementing the Plan should it go forward and, as of the time of our site visit, had not seen the final Plan. The state also has yet to commit any resources to develop any structure or provide incentives to support Plan implementation. Therefore, many of the policy levers, as described below and listed in more detail in [Appendix Table 22A-1](#), remain as potential levers:

- **Medicaid waiver:** The Plan proposes that the DSRIP programs created through the state’s Medicaid section 1115 waiver be used both as an opportunity to learn from the

program's many projects and as a vehicle to spread lessons from other initiatives through the DSRIP learning collaboratives.

- **Potential state executive branch action:** In addition to using the learning collaboratives to be developed under the DSRIP programs, the Plan proposes that the state expand on the DPP through a Public Health-Medicaid Managed Care Diabetes Education Project aimed at preventing diabetes among those enrolled in health plans for which the state pays, including Medicaid and perhaps the Texas Employee Retirement System. The Plan also proposes that the state's Medicaid Health IT office expand the current EHR Incentive Program to target providers currently not eligible for the federal program, and offer additional incentives for HIE and quality reporting among Medicaid providers.
- **Potential federal grants:** TIHCQE is committed to taking the lead on preparing and submitting the application for funding a Round 2 Model Test award should the state approve the continuation of the SIM Initiative.
- **State government-led coalition, task force, or commissions to drive voluntary change among providers, purchasers, or plans:** TIHCQE, created by state legislation, would take the lead in implementing the Plan should it go forward, in large part because many Plan elements align with that organization's purpose and priorities. Because it is a multi-stakeholder organization with representation from multiple payers, TIHCQE was identified as in a strong position to foster voluntary, multi-payer collaboration. This adoption of incentive programs would include such programs as the NCQA recognition standards, BTE and other quality measures, and incentives for HIE. TIHCQE would also provide opportunities for voluntary participation in or use of resources aimed at spreading and sustaining best practices, including a learning collaborative and a proposed database of health care innovation activities. In addition, TIHCQE is proposed as the lead for efforts to create a multi-payer data warehouse.

22.3.3 Intended Impact of the Plan

The Plan includes components that are expected to affect care delivery for the majority of Texans, thereby reaching 80 percent or more of the state's population. These include support for expanding and sustaining EHR and HIE adoption and use, expanding medical and health home models, community-based public health initiatives, sharing of information on innovations, and fostering collaboration.

Notwithstanding those proposed changes under the Plan, the need to develop payment and delivery system changes that would reach at least 80 percent of the Texas population was viewed by both those leading the planning process and many stakeholders, (including health plans and providers) as a constraint on the ability to design a Plan that would be most beneficial to health system transformation in Texas. Because the state has a limited history of multi-payer collaborative efforts, a high level of uninsurance, and distinct local and regional health care

markets, several stakeholders expressed frustration that the state could not pursue models that would have significant impact on a smaller share of the population, as a way to provide a successful template for how to undertake system change in the state as a whole. Ultimately, this perception of the need to leverage successful initiatives in the state as a way of building momentum for broader system change influenced the decision to include BTE in the Plan.

22.3.4 Proposed Next Steps

The Plan proposes to implement a SIM Council, which would be housed within the TIHCQE, to guide implementation of the Plan. The goals of the TIHCQE—to improve health care quality, accountability, education, and cost containment by encouraging provider collaboration, effective health care delivery models, and coordination of health care services—align with the Plan’s goals. However, it is not clear whether Texas will apply for a Round 2 Model Testing award, and its delay in submitting the final Plan has caused further uncertainty around the state’s commitment to continuing with the SIM Initiative. Although it is unlikely that implementation of the Plan would go forward without Round 2 funding, there is hope among HHSC and some stakeholders that TIHCQE would pursue some components of the Plan as part of its legislative mandate.

22.4 Discussion

The planning process for the Plan brought together a broad group of stakeholders, first with meetings within each region of the state and then in a statewide meeting. Although stakeholders appreciated the value of convening meetings to discuss strategies for transforming the Texas health care system, many felt the planning process remained at a very superficial level, with few details on how system change would be implemented. That characterization of the planning process, according to interviewees, likely reflects lack of visible engagement in the planning process among high-level state leaders, the short time frame and competing priorities for the state and stakeholders due to the overlap between the state's legislative session and the planning period, and a desire by HHSC for consensus in the key design elements across stakeholders.

22.4.1 Critical Factors Shaping the Plan

Critical factors that shaped the Plan include: (1) the state’s health care context, (2) the timing of the SIM Initiative, and (3) the process used for developing the Plan, according to stakeholders.

State health care context. Although there is broad agreement across Texas that there are opportunities to improve the health care system, stakeholders involved in this process did not perceive widespread enthusiasm for designing *statewide* strategies for system change. One interviewee summarized the challenge by saying: “It’s hard to come up with a statewide health

plan for a state that doesn't like statewide plans." There was broad agreement among stakeholders that a state-led, top-down strategy for health care reform is not well suited for a state as large, diverse, and regionally focused as Texas. A highly competitive market dominated by national health plans poses an additional barrier to multi-payer collaboration, according to interviewees, since health plans have different business models and philosophies, and are looking to distinguish themselves among the competition rather than to align with other payers. Ultimately, this context is reported to have resulted in a Plan that focuses on infrastructure development for collaboration and improvement, rather than on creating a large, statewide program. Selection of diabetes as a focus was viewed as a safe topic everyone could agree on to tie elements of the Plan together and begin developing targeted collaborations. Selection of TIHCQE to house the program going forward was not only because of similarities between the missions of the SIM Initiative and the organization, according to interviewees, but also because it reflected a general feeling that state government was not in the best position to implement the Plan given the need for strong private sector engagement.

Timing. The timing of the Initiative was also a critical factor that shaped development of the Plan. The leadership change that occurred within the state Medicaid agency between the application and the start of the Initiative left it without the project's initial state agency champion. In addition, the timing of the Initiative in conjunction with Texas's legislative session, which only occurs every 2 years, made it even more difficult for state staff to prioritize Plan development. Further, without a signal of clear commitment from the state to move forward with whatever plan was developed, it was difficult for many stakeholders to justify committing much time to the planning process. Finally, although also an opportunity for the SIM Initiative, the amount of activity around getting the Medicaid section 1115 waiver DSRIP projects started may have detracted attention from development of the Plan among those most interested in health care reform.

Planning process. The planning process itself played a critical role in Plan development. The decisions to start with a blank slate and to conduct a series of regional meetings, rather than begin with a more developed plan for sustained stakeholder engagement, made it difficult for stakeholders to contribute in a substantive way to the Plan. Although the statewide conference in Austin in August did appear to generate stronger engagement, a select group of stakeholders was ultimately influential in shaping the Plan as the deadline was drawing near. In particular, one-on-one meetings with TIHCQE and Blue Cross Blue Shield of Texas (whose use of the BTE program inspired incorporation of BTE into the Plan) were critical in shaping elements of the final Plan.

22.4.2 Lessons Learned

Texas's experience in the SIM Model Design initiative provides several lessons, according to stakeholders:

- **Moving from broad consensus on the goals for system change to concrete plans for system change is difficult.** Although there was broad agreement among stakeholders on the need for change, Texas does not have a strong history of collaboration. Several stakeholders noted a need to build trust and align incentives in the state before real collaboration is likely to occur, with collaboration most likely to start at local and regional levels.
- **Despite the state’s diversity, numerous opportunities for collaboration exist.** Stakeholders in Texas ultimately saw more opportunities for collaboration than they had envisioned when the planning process started. The planning activities have helped Texas stakeholders see a way to connect the dots across innovation activities already under way or being planned in the state.
- **Timing matters.** By overlapping with the legislative session, the SIM Model Design planning process was overshadowed by the legislative agenda. Further, the startup of TIHCQE and the Medicaid section 1115 waiver over the same period further stretched the resources of key stakeholders in the planning process. State agency staff and private sector stakeholders reported they had less time to devote to SIM Initiative planning activities than they would have liked, given other priorities and responsibilities.

22.4.3 Potential for Implementation

There is considerable uncertainty in the state as to the potential for implementation of the Plan. At the time of our interviews, most stakeholders had little information on the scope of the final Plan design but were optimistic that expanded collaboration efforts were possible within the state. However, most noted that such efforts would likely begin in local areas and regions of the state with an existing foundation of collaboration and in health care sectors where there are already coordination efforts under way, such as for case management for diabetes and other chronic conditions. Broad statewide changes were viewed as substantially more difficult and much less likely in the short run. Stakeholders expressed skepticism at the feasibility of implementing a top-down or state-focused plan for system reform in Texas. There is hope that the TIHCQE would provide an impetus for many of the types of changes envisioned in the Plan. However, with only two staff members, TIHCQE efforts to move forward with the Plan would require a substantial influx of funding. Under the Plan, six dedicated staff members would be hired for the SIM Council, which would be housed at TIHCQE and have responsibility for implementing the Plan. The financial analysis conducted by Deloitte in the Plan estimates that roughly \$45.7 million would be required to implement the Plan over 3 years. Such funding is unlikely to be available in the absence of a Round 2 Model Test award.

22.4.4 Applicability to Other States

Texas stakeholders have a strong sense they have little to learn from other states and other states may have little to learn from their collaboration efforts—given the unique elements

of the state, including its size, diversity, limited Medicaid program, and strong entrepreneurial focus. However, as a key component of the Plan is to support learning from the wide range of initiatives and innovations under way in the state, other states can benefit from learning about best practices in Texas, given the wide variety of models being tested in the state across such different local and regional markets.

22.4.5 Limitations of This Evaluation

This chapter was developed on the basis of the Texas State Health Care Innovation Plan, dated February 13, 2014, and case study interviews conducted between August and December 2013. Because of the timing of the interviews relative to the submission date of the final Plan, neither the process of finalizing the Plan, which took place between December 2013 and February 2014, nor stakeholder opinions about the final Plan, were captured by this case study.

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Appendix Table 22A-1. Models and strategies proposed in Texas Health Care Innovation Plan

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|--|--|---|--|---|
| Medical, health, and maternity homes and chronic disease management | | | | |
| Medical Home Training Program | Builds on TMHI; Senate Bill 7, 83rd Legislature, Regular Session, 2013, requires HHSC to implement a managed care model for SSI and SSI-related children that includes a health home | General population | State facilitation of system change *Health plans and payers provide financial and technical support to facilitate efforts toward development of medical and health homes; providers participate in training and learning collaboratives | SIM Council (proposed), payers, health plans, providers in small and medium-sized practices that have not obtained PCMH recognition |
| Medical Home Recognition Program | Modeled on HRSA's Patient-Centered Medical/Health Home Initiative | General population | State facilitation of system change *Payers and health plans provide financial support to the practices to obtain NCQA PCMH recognition | SIM Council (proposed), payers, health plans, select providers that meet NCQA standards to support in application process |
| Chronic Disease Care Recognition Program | BTE Care Recognition program | Individuals with specific conditions targeted | State facilitation of system change Proposed state executive branch action *Payers and health plans implement BTE *Medicaid contracts with health plans to implement BTE for Medicaid population | SIM Council (proposed), payers (including Medicaid), health plans, physician practices and other providers |

(continued)

Appendix Table 22A-1. Models and strategies proposed in Texas Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|--|---|--|--|---|
| Multi-payer engagement and alignment | | | | |
| Research and support for convening of payers, health plans, and providers for (1) Building Capacity for Multi-payer Collaboration and (2) Multi-payer Alignment on Diabetes Care Transformation and Prevention | Multi-payer Medical Home Initiative; Comprehensive Primary Care Initiative; BTE; National Diabetes Prevention Program | N/A | State facilitation of system change *Investment from TIHCQE | TIHCQE, payers, health plans and providers |
| Public health strategies | | | | |
| Public Health-Medicaid Managed Care Diabetes Education Project | Texas Diabetes Program; Community Diabetes Projects | Individuals enrolled in Medicaid managed care | State facilitation of system change *Investment from TIHCQE and Texas Diabetes Council | SIM Council (proposed), TIHCQE, Texas Diabetes Council |
| Implement the National Diabetes Prevention Program in Texas | National Diabetes Prevention Programs | Individuals with prediabetes, including Medicaid and the Employee Retirement System of Texas | Proposed state executive branch action *Implement program in Medicaid and the Texas State Employee Retirement System | SIM Council (proposed), Texas Diabetes Council, Department of State Health Services, Medicaid |

(continued)

Appendix Table 22A-1. Models and strategies proposed in Texas Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|--|--|---|---|---|
| Health IT | | | | |
| EHR Adoption Incentive Program | Medicaid EHR Incentive Program | N/A | Proposed state executive branch action *Expansion of Regional Extension Center assistance to new categories of Medicaid providers | Medicaid health IT division, Medicaid providers, providers in rural areas, providers in small practices, and behavioral health and LTSS providers |
| Expanding HIE Participation | | Chronically ill and those with behavioral health conditions, particularly the Medicaid population | Proposed state executive branch action *Use DSRIP learning collaboratives to engage HIEs and providers in disseminating lessons learned from use case | SIM Council, TIHCQE, Medicaid, LMHAs, with collaboration with willing hospitals in the same region |
| HIE Sustainability | HIE Cooperative Agreement Program | N/A | State facilitation of system change *Expand payer-sponsored payments to (1) providers for HIE utilization and (2) certified HIEs for connecting providers Proposed state executive branch action *Provide incentives for (1) provider utilization of HIE and reporting quality measures to Medicaid, and (2) certified HIEs for connecting providers | SIM Council (proposed), Office of e-Health Coordination, THSA, HIE Cooperative Agreement Program, Medicaid Health IT, payers (including Medicaid), health plans, providers, local HIEs and health information service providers |
| Spreading and sustaining best practices | | | | |
| Health Innovation Learning Network | Template based on model developed by Texas Medicare Quality Improvement Organization for the Comprehensive Primary Care initiative | N/A | State facilitation of system change *Investment from TIHCQE | SIM Council (proposed), TIHCQE, physician practices and other providers |

(continued)

Appendix Table 22A-1. Models and strategies proposed in Texas Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|---|---|-----------------------|---|---|
| Sustaining Practice Transformation in Medicaid Managed Care | | Medicaid | Proposed state executive branch action *Use DSRIP learning collaboratives to share information | SIM Council (proposed), TIHCQE, Medicaid, practices serving Medicaid population |
| Texas Health Care Innovation Tracking Center | | N/A | State facilitation of system change *Investment from TIHCQE Use Health Innovation Learning Network (proposed) to share information | SIM Council (proposed), TIHCQE, Medicaid, payers, health plans, and providers |
| Collaboration for Public-Private Data Sharing | TIHCQE work group | N/A | State facilitation of system change *Investment from TIHCQE | TIHCQE, payers, health plans, and providers |

¹Policy levers include Medicaid waivers; federal grants (including Round 2 SIM award); state laws; state regulations; state investments (e.g., in public health programming); foundation grants; employer-led coalitions to drive change among providers, purchasers, or plans; state government-led coalitions, task forces, or commissions to drive voluntary change among providers, purchasers, or plans; state purchasing contracts; and state-level (Governor-initiated) executive policy directives.

Acronyms: BTE = Bridges to Excellence, DSRIP = Delivery System Reform Incentive Payment, EHR = electronic health record, HHSC = Texas Health and Human Services Commission, HIE = health information exchange, HRSA = Health Resources and Services Administration, IT = information technology, LMHAs = local mental health authorities, LTSS = long-term services and supports, N/A = not applicable, NCQA = National Committee for Quality Assurance, PCMH = patient-centered medical home, SIM = State Innovation Model, SSI = Social Security Insurance, THSA = Texas Health Services Authority, TIHCQE = Texas Institute of Health Care Quality and Efficiency, TMHI = Texas Medical Home Initiative.

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23. Utah

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Utah's health services sector is highly concentrated, while its insurance market is less so. Some health reform initiatives are already under way, including the introduction of Medicaid accountable care organizations (ACOs) and some progress in value-based purchasing (VBP). Stakeholders in Utah observe a state culture that favors state-based and private means of achieving reform.

Utah's State Innovation Models (SIM) Model Design process began with a narrowly focused, university-centric proposal but later became a broader, more systemic approach that built on earlier, similar public-private planning in the state. The planning operated within the state Department of Health (UDOH), which supplied staff support to five stakeholder work groups reporting to an Executive Policy Group (EPG). The EPG was led by Utah's Lieutenant Governor, who was personally delegated by the Governor. Key relevant stakeholders such as CEO-level stakeholders, state agency directors, and experts were represented in the EPG and work groups.

A primary aim of the Utah Health Care Innovation Plan (the Plan) is to accelerate adoption of VBP. Supportive initiatives focus on health information technology (health IT) and education of practitioners. Additional initiatives include using health IT to facilitate documentation of end-of-life preferences for Utahns so they can receive care with dignity, respect, and efficiency; to increase access to primary care and behavioral health; and to create community-clinical linkages and healthful environments. The Plan does not envision using state legislation, regulation, or payment requirements, but rather voluntary private sector action and better data on which to build private and state decision making. The Plan anticipates reaching 80 percent of the state's population through VBP and 60 percent of the services sector through quality metrics.

23.1 Context for Health Care Innovation

Utah's State Innovation Model (SIM) Model Design Initiative grew out of prior state interests in health reform.

Populations of interest. Utah's population of 2.8 million is 80 percent concentrated in urbanized counties in and around Salt Lake City. Hospitals, clinics, and physicians also cluster there (Economists, Inc., 2006). The rest of the state has low population density and faces typical rural challenges in access and other attributes of a good delivery system. The population is very

homogeneous. Fully 89 percent are non-Hispanic whites; 92 percent were born in the United States, mostly in Utah (2010 census).

Utah ranks low in health spending and high in health status and outcomes. The state occasionally falls below average on metrics of delivery system capacity, as in the supply of primary care physicians and hospital beds (SHADAC, 2012). Uninsurance is slightly lower than average, but Utahns are no more likely than others to avoid care because of cost (KFF, undated). Identified shortcomings include a “Hispanic health gap” (Dentzer, 2012) within the rapidly growing Latino subpopulation, geographic disparities in access to care and behavioral health services, and limited use of health IT and readiness to alter traditional modes of operation.

Delivery and financing system. The health services sector is unusually concentrated. Four systems account for some 90 percent of hospital care. Intermountain Healthcare—a nonprofit, vertically integrated system—has more than half the hospital market. University of Utah (U of U) Healthcare accounts for about a quarter. IASIS and MountainStar (a division of Hospital Corporation of America) together have over 10 percent. More than half the state’s physicians are said to practice mainly within Intermountain, while virtually all have some connection to the system, including its insurance arm. In addition, U of U–employed physicians constitute nearly a quarter of the state's total. Stakeholder interviews suggested that few practices constitute patient-centered medical homes, although the new Utah CO-OP (Consumer Oriented and Operated Plan, Arches Health Plan) intends to promote that mode of practice, and UDOH (2011) wants to encourage a form of medical homes under Medicaid reform.

The market for insurance is less concentrated than for services delivery. Intermountain’s SelectHealth insurance arm has about 700,000 members, a quarter of the population. It is one of the state’s two largest carriers, along with Regence Blue Cross Blue Shield. There are numerous commercial insurers, including UnitedHealthCare, and the market for large employer coverage is perceived as competitive. Four plans serve Medicaid, and in recent years have had no- or partial-risk contracts (Kaiser Commission on Medicaid and the Uninsured, 2012). In 2013, the Medicaid plans were moved to full risk contracts. These include three hospital system–related plans (from Intermountain [SelectHealth], IASIS [Health Choice], and U of U [Healthy U]); and Molina Health Care, a multi-state carrier.

Employee-only plans include the Public Employees Health Program (PEHP) and Deseret Mutual (employees of member organizations). Policy makers worry about the robustness of Utah's small group market—one reason for creating the state’s early insurance purchasing exchange, now known as Avenue H, and the new CO-OP, created in 2012 by local leaders using loans under the Patient Protection and Affordable Care Act (ACA) and headed by the founding head of the PEHP (Stewart, 2012).

Political context. The political culture in Utah favors developing policies that are state-specific and rely more on private sector action than on public sector regulation. Stakeholders confirmed that Intermountain Healthcare and U of U Healthcare are the two most potent political influences in health policy making.

Prior public developments in health reform. Starting in 2005, when prior Governor Jon Huntsman made it a top priority (Girvan, 2010), state health reforms have included Avenue H, a purchasing exchange to facilitate employers' moving to defined-contribution health care and encourage enrollee responsibility for their own choices; promotion of electronic health records (EHRs); encouragement of consumer-directed insurance; an all-payer claims database (APCD) still in development; and additional limitations on malpractice litigation.

A March 2008 statute (H.B. 133) created the Health System Reform Task Force, which has been repeatedly reauthorized to continue evolving Utah-specific approaches and inform general health policymaking. In 2011, the state passed legislation to create Medicaid ACOs (NASHP, 2013), which began in January 2013 for the four largest counties (with 70 percent of the beneficiaries) (Anderson, 2013). The new ACOs are Medicaid managed care organizations under new risk-based contracts (Kaiser Commission on Medicaid and the Uninsured, 2012) and are not provider-led.

The current Governor Gary R. Herbert convened his first daylong Health Summit in 2011 to consider "Utah Solutions for a Health Economy and Community," which included sessions on developing a "Strategic Health Plan for Utah," a clear precursor to the SIM Initiative. The influence of medical liability arose repeatedly during deliberations, and after the summit Governor Herbert tasked Lieutenant Governor Greg Bell to study how Utah could go beyond its already strong tort reforms. At the next year's summit the Governor called for wellness strategies to make Utahns "the healthiest people in the nation ... at an affordable cost," following his guiding principles of "personal responsibility, living within budgetary constraints, allowing the states to be innovators, providing help to those who need it in a compassionate way, and relying on free market principles" (UDOH, 2012).

Utah joined the multi-state lawsuit against the ACA, enacted legislation requiring legislative approval of any Medicaid expansion or other ACA funding, and has chosen federal operation for the ACA's individual insurance marketplace (Cauchi, 2014). Utah will operate the small business marketplace, however, building on Avenue H (KFF, 2013). In January 2014, the Governor announced that doing nothing on Medicaid expansion was not an option for the state (Stewart & Gehrke, 2014). No Medicaid expansion bills passed during the 2014 session of the Utah Legislature (Gehrke 2014). But Governor Herbert has stated that he will continue discussions with CMS to develop a Utah solution to the issues posed by the gap left without the Medicaid expansion (Roche 2014).

Prior private and public initiatives relevant to the SIM Initiative. A number of innovative initiatives in financing, delivery, or health IT were already under way in Utah before the SIM Initiative. In addition to the Medicaid ACOs already noted, these include a Beacon health IT project within a nongovernment organization consortium and a health innovation grant involving Intermountain. Limited progress toward VBP has also occurred. (For a list of projects and developments, see UT SIM Project, 2013c, pp. 24–45, especially Table 4.)

23.2 Planning Infrastructure and Process

Utah’s Model Design process began, as noted, with a narrowly focused, university-centric proposal, which was submitted from UDOH to CMS in fall 2012. This embodied researchers’ liability reform ideas as modified by the Lieutenant Governor’s work group established after the 2011 summit. The initial proposal was to test innovation in provider-patient communication as a way to increase medical safety, decrease malpractice claims, reduce defensive medicine, and make medical culture more patient focused and outcomes oriented. The Governor specifically chose the Lieutenant Governor’s SIM strategy in preference to a broader SIM approach suggested by a nongovernment source, according to one nongovernment stakeholder. The initial proposal began with reasonably well-formulated ideas and did not envision any formal planning structure.

To broaden the original proposal, state staff used the earlier summits’ ideas as the conceptual starting point for developing the Plan. This transformation reflected expectations from CMS and also the broader earlier Utah thinking. Changes in the SIM Initiative focus continued into the early months of the Model Design phase.

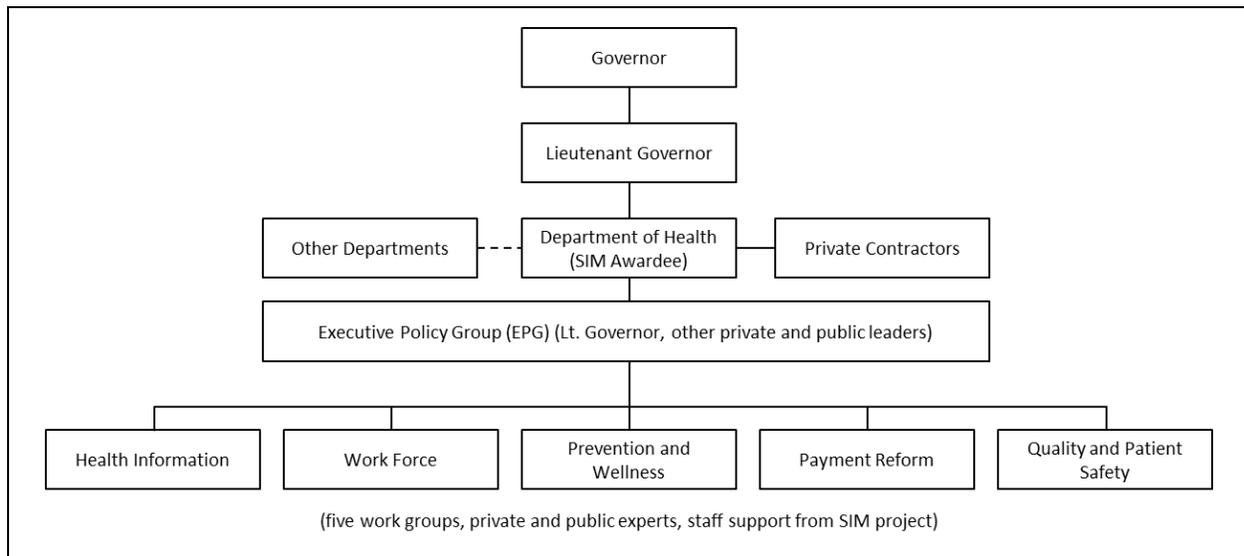
Governance and management. The modified SIM Initiative marshaled a very high caliber of state and private decision makers to generate, assess, and recommend reform ideas. The planning process resembled that of the prior summits but was more elaborate, overseen by a blue-ribbon EPG and designed to reach more action-oriented recommendations in a formal Plan. Like the summits, the Initiative structure relied on work groups, whose five issue areas were similar to those of the prior work panels (UT SIM Project, 2013a).

The SIM award was obtained by UDOH, but with approval of Governor Herbert (*Figure 23-1*). Lieutenant Governor Bell was again tasked to lead this health reform effort, working closely with UDOH and chairing the EPG. The UDOH executive director delegated day-to-day management to a Deputy Director and his team. Project decision making occurred within the EPG, which provided overall guidance, and the subsidiary work groups.

Stakeholder engagement. The Model Design process reached out to key relevant stakeholders statewide. The Lieutenant Governor and UDOH SIM leaders together recruited the EPG’s members and designated the chairs for each work group. These participants were high-

level leaders in business, health care, and government—including two state legislative committee chairs; a mayor; three heads of state agencies; the CEOs of Intermountain, U of U Healthcare, and MountainStar hospital systems; and leaders of the medical and hospital associations. These leaders participated from the first meeting in April 2013 through the last in November, seldom sending surrogates. Some also served on work groups.

Figure 23-1. SIM Grant Project Structure



The work group chairs and SIM support staff from UDOH and the U of U together recruited work group members. In some cases, additional people asked to be invited; some were and some were not. Work group members added a mix—as one stakeholder termed them—of additional “big fish” (CEOs of SelectHealth and Regence, heads of the United Way and AARP, and House Chair of the legislative task force and Chair of a Senate committee) and practical experts “below sea level,” in health IT and public health, for example. Each work group was staffed by multiple UDOH or U of U personnel who worked closely with work group (co)chairs.

Participation from the behavioral health sector was overlooked in initial planning, although the EPG included the head of its lead state agency, the Department of Human Services (DHS). CMS pointed this out after review of an initial stakeholder engagement plan, and DHS staff thereafter participated in work group sessions. After the fact, UDOH staff members were very pleased with these contributions.

Overall, stakeholders described their participation in Utah’s Model Design process as active—although some work group members did not attend regularly and some nonmembers attended on an ad hoc basis. In all, state officials estimated that more than 100 stakeholders participated.

Less engaged stakeholders. Stakeholders disagreed on the extent to which the planning process was missing any perspectives. For example, some commented on consumer underrepresentation. The SIM stakeholder listing includes only one name designated as a consumer advocate (UT SIM Project, 2013b). Some expressed regret that time pressures made it impossible to hold any town halls on the Plan or provide for any public comment on it, because no draft Plan preceded the official submission to CMS at the end of December. But others noted that well-engaged politicians represented the general public and that the 2013 Summit was well advertised, open, and attended by many interested people.

Rural participation was low, although invited. Plausibly, time costs were important barriers, as all SIM activities occurred in Salt Lake City and call-in participation was not available. Reimbursement was available for room and board, but that inducement often proved insufficient. A key staffer commented that the tight time frame had not allowed for general public comment or taking the final Plan on the road to outlying areas. But some stakeholders said that many participants were familiar with rural issues, even if not rural residents themselves.

Decision-making process. The EPG assigned each work group to build on prior work. Each group operated without centrally imposed procedures. To keep the overall Plan manageable, there was strong central encouragement for each group to generate only two or three aims and associated drivers, using the CMS framework. The EPG itself was said to operate entirely by consensus, with only three formal votes occurring during the course of its meetings. Voting software was purchased and sometimes used in the work groups. Some stakeholders praised secret votes as a way to surface unexpressed opinion. But one told a lengthy story about how the vote on the group's final two aims had been followed by "a lot of discomfort and grumbling in the room." Discussion was reopened, opinions coalesced, and a revote resulted in a different, more inclusive decision. Overall, consensus was the dominant approach.

Each of the groups held several full-group meetings. Most brainstorming, discussion, and review of evidence occurred in those meetings. However, considerable email interchange occurred between sessions, notably among the health information work group members. Also between sessions, SIM Initiative staff met and discussed observations with the group chair or cochairs as they wrote up findings and prepared materials for ensuing sessions. For some groups, a few particularly insightful members were invited into extra discussions with the chair or cochairs. This informal approach created a more flexible, executive committee-like structure to advance the thinking that would be laid before the next formal session.

The work groups each made final decisions on their aims and drivers during the summer, which were approved with little change by the EPG and then by the Governor's Office. The respective chairs presented these findings at the 2013 summit in September. Thereafter, the groups finalized specific implementing initiatives and specific measures to monitor accomplishments. Each group produced lengthy internal reports of recommendations; SIM

Initiative staff examined them for duplication, conflicts, and cross-group synergies, again working in conjunction with group chair(s) and other key group members.

A slimmed-down synthesis was presented to the EPG and approved in November. Concurrently, budget approval enabled outside contractor Leavitt Partners to provide financial analysis of some of the aims. Thereafter, SIM Initiative staff produced a final Plan, which was reviewed by a few key EPG participants, then reviewed and approved by the UDOH executive director's office. The final Plan submitted to CMS in December 2013 was the first draft made public. Its organization and emphases varied from that of the five work groups.

SIM Initiative staff did much of the project work. Participants interviewed saw that work as enabling or facilitating rather than directive.

State resources committed to the planning process. Model Design funding supported much state agency staff time and was supplemented only by in-kind contributions from nongovernment stakeholders. No additional state or foundation contract dollars were committed to the process. However, the in-kind contributions were substantial, not merely for attendance at meetings but also for participation between meetings and production of data and presentations. Further, the Model Design process paralleled and piggybacked on others, including those of the legislative task force. SIM Initiative staff thought the dollar funding was adequate but time resources were tight. Some work group members liked the tight schedule, which they said inspired focus. Staffing levels were seen as appropriate.

23.3 The Utah Plan

The Plan proposes to accelerate the growth of VBP in the state. Its central goal is “moving Utah from a fee-for-service system to a value-based payment system” (UT SIM Project, 2013c, p. 45; see also p. 3). Participating stakeholders came to consensus on a number of ways to support the partial VBP already in progress, encourage its spread elsewhere, measure the accomplishments of competing private approaches, and study which work best. A number of enabling strategies are also included.

23.3.1 Models and Strategies

The Plan specifies a number of key models with associated initiatives, action steps, and performance metrics for each. Key models and strategies are described below. [Appendix Table 23A-1](#) provides preexisting initiatives, populations addressed, main policy levers, and implementation entities for each of these models and strategies.

Value-based purchasing. The Plan focuses on promoting VBP as an approach to transforming health care, without favoring one delivery system model over another. Delivery system models in Utah include medical homes, private health maintenance organizations,

Medicare Advantage plans, Medicaid ACOs (administered by Medicaid managed care organizations), and private ACOs. However, they incorporate only partial VBP rather than full VBP; that is, they “have some incentives to reduce costs” (UT SIM Project, 2013c, p. 48) but insufficient focus on quality. Full VBP calls for capitating providers for serving a defined population—basing payment, at least in part, on meeting defined health care quality metrics (UT SIM Project, 2013c, p. 48). The only existing full VBP in Utah is the Medicare ACO operated by the Central Utah Clinic, but its enrollment is only about 9,000 beneficiaries. The Plan calls for accelerating development of the various delivery system models from partial to full VBP.

The Plan seeks to achieve full VBP by encouraging and supporting its development where forms of VBP do not already exist. Both public and private leaders believe that strong market and administrative forces are already promoting VBP—with many approaches at different stages of development within both the public and private sectors. Seeking a single, state-favored approach would slow down progress in Utah, according to key stakeholders. The intent is to act as an accelerator, for example within and across “10 groups that are already implementing some sort of VBP effort,” in the words of one stakeholder, and to increase the pace of innovation. The Plan proposes market-enabling initiatives to support and facilitate VBP—notably, workforce education and training, health IT tools and value-based metrics to help providers and payers make purchasing decisions, and infrastructure to link providers with community resources—and to monitor VBP developments across the market.

End-of-life preferences. The Plan proposes facilitating end-of-life preferences for Utahns, with goals of enhancing dignity, respect, and efficiency. Strategies include standardizing documentation used for electronic Physician Ordered Life Saving Treatment (ePOLST) directives, making them more readily accessible through health IT, and training providers in end of life–related communication.

Integration of behavioral and primary health care. Strategies include enhancing access to primary and behavioral health in rural areas, encouraging integration of behavioral health into primary care, and promotion of the most effective practices in behavioral health prevention and treatment.

Workforce development. The Plan proposes enhancements in workforce education and technical assistance for some providers, to help them operate under VBP initiatives. In general, the Plan appears to target assistance to those not already within an organized chain or other system, notably including independent rural facilities.

One key component in the Plan designed to support VBP is to provide training on provider-patient communication, with the intent of reducing provider risk and liability. This component was the original reason for submitting a SIM Model Design application, and interviewees said it remains important politically for Plan implementation.

Public health strategies. The Plan emphasizes two public health strategies: (1) increased training and use of community health workers (CHWs), who have the potential to build bridges both within health care and between health services and other wellness enhancing sectors; and (2) alignment of wellness efforts across public, private, and nonprofit sectors within at least one community around a common agenda. Public health is said to be “siloed” field, and the Plan suggests that aligning forces and creating community-clinical linkages can promote healthful environments and better health. Stakeholders said that this approach builds on the work of the United Way of Salt Lake (which contributed to work group membership and information) and the collective-impact model from Stanford University.

Health IT. Investments in health IT, which is described in the Plan as the “backbone” of payment and delivery redesign, provide “the data infrastructure and interoperability” that support progress on “medical homes, shared savings, ACOs, and payment reform” (UT SIM Project, 2013c, p.47). Because VBP must be able to track patients across time, providers, and sectors, Utah intends to improve its nascent statewide master person index (sMPI); bolster EHR, especially in rural areas; make its clinical health information exchange (cHIE) more secure; and increase the utility of its evolving APCD.

Enhanced data analysis. The Plan envisions public-private creation of statewide outcome metrics of value in health care, using data collected from payers. To ensure their utility, these are to be agreed “by consensus among stakeholders” (UT SIM Project, 2013c, Appendix C, p. 127). Similarly, UDOH intends to create capacity within the APCD “to become the primary, and potentially the sole, source of value metrics for all providers and payers” (UT SIM Project, 2013c, p. 96).

Because the private sector can benefit from careful study of how different approaches are faring, the Plan calls for detailed study of three leading VBP examples from entities that volunteer to participate in the study. In addition, the Plan proposes to develop workforce projection methodologies that would track the prevalence of primary care and behavioral health care providers working together in teams and in VBP environments. This strategy would involve, for example, increasing data reporting on primary and behavioral health and building population statistics and outcomes into projection methods.

23.3.2 Policy Levers

This section reviews the key levers the state is likely to use to implement the Plan; [Appendix Table 23A-1](#) summarizes all levers discussed. Like the Model Design planning process, the Plan relies heavily on encouragement and facilitation of private sector activity, executive branch work, and partnering between the state and localities and with private businesses, including health practices and insurers. Notably, many of these outcomes—such as

having 80 percent of covered lives in a VBP environment or having 60 percent of providers use key health IT tools—are dependent on voluntary action by the private sector.

The Plan development leaders avoided proposing new legislation or payment requirements. One nongovernment stakeholder suggested the state might “actually pull some legislative levers,” but that Utahns are not “awfully willing to do [so].” Some administrative rule making will be needed, for example, to make Medicaid changes (e.g., UT SIM Project, 2013c, p. 31) or “to regulate the sMPI governance and operation” (p. 93). Still, even matters to be implemented by rule mainly involve prior consensus building among stakeholders.

Utah policy makers sought to piggyback on existing initiatives wherever possible. One example is the focus on end-of-life issues, which had a precursor in the Salt Lake City Beacon project operating since 2010. One stakeholder said that end-of-life wishes and clinical orders constitute an early form of general information sharing people care about—and thus can be used to achieve proof of concept and facilitate broader uses of information exchange, which is important for moving to effective VBP.

Many efforts would require funding, but the Plan is silent on how funds would be obtained. Appendix B of the Plan assigns dollar values to each aim or intervention, totaling some \$40 to \$50 million (pp. 127–28). This array seems to anticipate Round 2 Model Test funding; unlabeled lines appear to reflect loading costs on top of direct spending. Some interviewees reflected an implied intent to move toward a Round 2 application, but the Plan does not explicitly mention it. However, approval for this application was obtained during the 2014 session of the Utah Legislature (UT SIM Project 2014). No formal indications are evident on possible reallocations of administrative funding, which seem likely to occur—for example, to formulate and promulgate rules, effectuate contracts, and coordinate training and collaboration. Finally, private support is not tallied but is clearly anticipated. Indeed, two leading provider-sector decision makers said they expected their organizations would track and analyze performance of initiatives, even in the absence of federal or state support.

23.3.3 Intended Impact of the Plan

The Plan indicates that its initiatives are meant to touch all of Utah. Its various supportive and informational initiatives would offer some form of help to everyone. VBP is projected to reach 80 percent of state population, quality metrics to reach 60 percent of the service sector, and security training for users of key health IT tools to reach 100 percent (UT SIM Project, 2013c, Appendix C, p. 129). Other goals are more modest. Under the Plan, 50 to 60 percent of Utah patients diagnosed with a serious or terminal illness are projected to have an ePOLST on file, and 25 percent of adults to complete an Advance Directives form. The Plan is unclear about what share of rural residents the proposed strategies are projected to reach.

23.3.4 Proposed Next Steps

The state has released a SIM Transformation Timeline that outlines concrete implementation steps for 2014 through 2016 (UT SIM Project, 2013c, Appendix C, p. 129). On their face, most initiatives can proceed without federal funding, but their scope might be different.

The state aims to begin implementing all major components of the Plan in 2014. Implementation goals for 2014 include developing health IT infrastructure, awarding contracts and dispersing funds for infrastructure operation and technical assistance provision, designing curricula for provider education, identifying provider leaders for disclosure and resolution initiatives, and convening a coalition to determine common wellness goals in a selected community. In 2015, the state intends to monitor the adoption of health IT infrastructure, provide training to providers on performing in value-based environments, enhance access to behavioral health services, implement a CHW model, and implement an aligned community wellness effort in a selected community.

23.4 Discussion

The Plan was developed with the benefit of high-level stakeholder participation and a commitment from the public and private sectors to leverage their existing programs and make changes through voluntary action. In addition, Utah balanced CMS' guidelines for the SIM Model Design Initiative with a political culture that seeks state-specific solutions to produce a Plan to meet Utah's needs, and to achieve federal goals for state plans that have the potential to improve health and health care for the preponderance of the population.

Utah's Plan development process included very high-level decision makers and kept them actively involved through 8 months of meetings. Public-private groups or task forces are a common approach in Utah (Economists Inc., 2006), with some more blue ribbon than others; and all Plan development meetings had very high-level participation. Moreover, Utah's approach to Plan development was described as using advanced thinking and tackling controversial issues.

Utahns' core political philosophies manifest themselves in both the models and strategies included in the Plan and the policy levers identified for its implementation. First, policy makers emphasized that better value is the key concept for reform and that focusing on quality can lead to long-run efficiencies—that bad quality, gold plating, and malpractice disputes promote waste, and costs can be cut without overt cost-cutting (see James & Savitz, 2011 on prior developments). Stakeholders expressed concern that federal commitment to overt cost cutting might derail Utah's approach.

Second, the voluntary nature of most anticipated change allows the Plan to offer help in innovating to everyone, although expecting VBP to reach 80 percent of the population in 5 years was described as possibly a “stretch goal.” Medicare is outside the state’s aegis, and it enrolls about 10 percent of Utah’s population.

Stakeholders were very satisfied with the Plan development process and enthusiastic about the Plan expected to be promulgated from the planning work. However, several stakeholders also expressed lingering resentment at the Plan being moved away from its original liability-safety focus to broad reform. Nonetheless, better education for physician-patient interactions, and learning better how to resolve disputes, remain part of the Plan—but as an aspect of education for VBP rather than in a separate status as in the original work group planning. This inclusion is critical for political acceptance in the state.

23.4.1 Critical Factors Shaping the Plan

Key influences were Utah’s political culture, the people involved in the planning process, and use of data, according to stakeholders.

Political culture. Utah’s political culture did not directly influence the specifics of the Plan but clearly served as a boundary constraint and general shaper of options and opinions. Stakeholders did not describe even considering regulatory approaches, for example. The final Plan opted throughout for supporting and accelerating existing initiatives rather than reinventing the wheel or, most especially, mandating a single approach to VBP; this resulted in an emphasis on creating useful tools and generating reliable data to support both private and public decision making in the future.

The people involved. Plan development coordinated closely with the legislative task force, which is generally recognized as hugely influential on relevant health issues (Stewart, 2013), and with the two key preexisting health data committees. The House Chair of the two-chamber task force (an insurance broker) cochaired the payment reform work group. Stakeholders suggested that payment reform is the lynchpin of ongoing reform because it changes incentives throughout the health care delivery system. Moreover, future revenue streams are under legislative control. The willingness of existing program administrators and of private stakeholders to change workforce approaches, integrate clinical services with behavioral health and community health, and cooperate in generating needed health information would depend on those revenue streams. The House Chair of the two-chamber task force also favored participation at the executive-level from individual organizations rather than representatives from provider associations, which influenced who participated in the planning process. Plan development staff were encouraged, not to let the political leadership worry about political feasibility, but to focus on helping the groups figure out the best ideas. The two ongoing health IT work groups were also closely involved.

Utahns often see new government grants and directives as impediments to existing positive trends. Private sector stakeholders did not see the Model Design process that way, because it facilitated the ability for both private and public participants to shape the Plan. As a result, the Plan proposes to support, inform, and encourage innovation rather than to regulate it.

The most influential people appear to have been the Lieutenant Governor, the CEOs of Intermountain and U of U Healthcare, and the CMS project officer, who was seen as very helpful. CMS greatly influenced both the scope and some of the particulars of the Initiative. This stirred initial resentment, but the final process and Plan generated a lot of enthusiasm.

Use of data. Plan development was not data-driven in the sense that its process involved no “epidemiologic profile of the state,” as one person put it, or in another’s words: “We didn’t rely too much on some of the statistics about how fat we are.” It seems that the process was too broad and moved too rapidly for data mining. Data were brought in as needed in focused presentations by experts or community members. The Plan’s write-up brought in some data to provide rationales for the aims and initiatives chosen. But some of the Plan data were generated after the last work group meetings, through the work of the late-funded economic consulting firm.

One datum had great influence: initially omitted behavioral health experts showed statistics that behavioral issues were the number two reason for emergency medical service calls statewide. This statistic drew considerable attention at the Governor’s summit in September 2013. In the end, behavioral health became central to the final Plan, owing to both the people involved and the data.

Going forward, information is described as playing a key role. There was strong consensus among stakeholders that better and more real-time data are needed to support better future clinical decision making and management for improvement in all areas.

23.4.2 Lessons Learned

Utah’s experience with its SIM project suggests several lessons, according to stakeholders.

- **Which individuals are involved matters.** This was especially true with regard to the leadership and clout in both private and public sectors seen in the Utah Plan development process, as already noted. Stakeholders repeatedly emphasized the importance of the heavy involvement of the Lieutenant Governor, perceived to be close to the Governor and legislative leaders. His influence is also credited with attracting such high-level and active participation in the process. The CMS project officer, as noted, was also very influential in providing guidance that broadened the focus of the planning process. In addition, the presence of behavioral health care experts and technical staff, as described below, shaped the content of the Plan.

- **The initial 6-month time period was insufficient.** The project’s design was in substantial flux for some months before and even after the project’s official start. The name and focus of the fifth work group, for example, changed after Plan development was under way. Moreover, subsequent winnowing and sharpening of the work groups’ efforts took time, as did writing the Plan. The 3 to 4 months available for the full work groups to generate their preferred aims and drivers was sufficient, according to several stakeholders, and even helped them focus on being efficient. One explained that people in Utah are accustomed to 45-day legislative sessions. But no time remained for town halls or a public comment period before the Model Design phase ended.
- **The Model Design process encouraged new collaborations across different types of stakeholders that yielded multisector support for several proposed strategies.** The process built bridges between providers and insurers of health services, on the one hand, and behavioral health and public health, on the other. Multiple stakeholders described “ah ha” moments when “the light went on” and breakthroughs were achieved in understanding the role of CHWs, or the coordinated provision of primary care and behavioral health, for example. Those moments reportedly translated into much higher prominence in the Plan for comprehensive services and population-oriented initiatives, management, and tracking of results. Adding participation from people with behavioral health experience to all work group deliberations appeared to alter outcomes: behavioral health began as “not at the table” in the words of one stakeholder but ended as part of one of only four final aims in the Plan—to “increase access to primary and behavioral health.” However, challenges remain to operationalize, then institutionalize, such changes in attitudes. Agreeing to the Plan is described as easier than agreeing to shifts in funding or economic and professional power.
- **Successful planning may need to combine technical expertise with real-world savvy and political influence.** In Utah, this occurred through the composition of the work groups and the EPG. SIM Initiative staff and political leadership recruited high-level private and public decision makers, especially as heads of the work groups and as members of the EPG. The work groups brought in both technical expertise and practical experience. Stakeholders noted that this blend achieved a good level of buy-in to the Plan among very influential Utahns, in the private sector and in government. Alternative approaches to development of public policy may emphasize soliciting recommendations from outside experts or responding to grassroots politicking by advocacy groups. The former may produce technically expert plans that lack political viability or are difficult to implement. Wholly political approaches may have legislative clout but only haphazard technical merit and little practicality. Utah has attempted to have the best of both these worlds, according to stakeholders.
- **Demand for immediate cost containment can impede longer run, innovative bending of the cost curve.** That, at least, is a strongly held view in Utah. Many leaders are deeply committed to quality improvement as a way to increase value, and often also to cut costs (see James & Savitz, 2011 for an example often quoted by

stakeholders). Utah is deeply committed to this approach, and a number of stakeholders worried that overemphasis on direct cost cutting nationally would hurt them in relations with CMS.

23.4.3 Potential for Implementation

On paper, the SIM proposals seem readily implementable. The feasibility of implementation would depend on the future balance of positive and negative factors. Several strong positive factors support implementation. The enthusiasm and energy generated by the Model Design process was much greater than in the earlier, less organized health summit, whose planning was never implemented. Key health care interests have bought in, at very high levels of management, including the two most dominant health care institutions in the state. Moreover, the Governor was very supportive of the Plan as a way to formulate a state-specific agenda and promote malpractice-related reform. The Lieutenant Governor personally devoted even more energy to the process and remains influential in his new role as executive director of the hospital association. The proposed initiatives also have more momentum because they build on existing Utah operations and structures. Finally, many of the recommendations can be implemented to some extent without large new appropriations. Even without new funding, several stakeholders at large organizations said their entities would probably assess performance of innovations using their own funds.

One possible hindrance to Plan implementation would be if key actors view parts of the Plan as externally imposed rather than state stakeholder driven. In addition, the Plan envisioned "acceleration" of existing developments and programs, which would require some new funding from a Round 2 grant or from state appropriations. The Plan was not completed in time to be considered in the Governor's budget, although the legislature did give UDOH approval to seek new SIM funding, according to stakeholders.

In sum, the key to the future of the Plan seems to be the durability of participants' commitment. Key leaders have agreed on some next steps, but the challenge is to maintain their engagement in developing more specific plans for implementation, with possible SIM funding. As one informant said, "the devil is in the details."

23.4.4 Applicability to Other States

Utah's political culture and its homogeneity make it different from most other states, according to stakeholders. Utah's progress, however, could be instructive for the nearly half of states that limit their involvement federally-driven health policy efforts. The changes proposed in Utah are consistent with the intent of innovations that CMS and some states are seeking, although the desired transformation is far more reliant on private initiative, and there is great insistence that the surrounding rhetoric and some parts of the approach be very Utah specific. As to the Plan's general content, initiatives seem sufficiently nondirective to apply nearly anywhere.

Regarding the Utah Model Design process, it could be hard to duplicate in a larger state or one with more adversarial or complex power structures. Utah is small, with a concentrated health care market and a relatively small number of key leaders. Given the close involvement of the Governor, the Lieutenant Governor, and the legislators, the SIM Initiative could obtain high participation and leadership from high-level people in the relevant spheres.

23.4.5 Limitations of This Evaluation

This report draws upon interviews conducted from September 2013 (including at the Governor's Summit in Salt Lake City) to early December 2013, and therefore does not reflect stakeholders' opinions on the actual Plan, which was available for review only in early January 2014.

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Appendix Table 23A-1. Models and strategies proposed in Utah Health Care Innovation Plan

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|---|--|--|--|--|
| <p>Value-based purchasing</p> <p>Encourage voluntary adoption of VBP models by providers and payers:</p> <p>Encourage transition of existing medical home-like models and ACOs to full VBP, which calls for providers to be compensated on a capitated basis for serving a defined population and compensation is based, at least in part, on meeting defined health care quality metrics</p> <p>Strategies for supporting, facilitating, and encouraging transition to VBP models, described in subsequent rows under investments in health care delivery system workforce, investments in health IT, and investments in enhanced data systems analysis and reporting</p> | <p>Health Care Innovation Award: “Disruptive Innovation @ Intermountain Healthcare” (a new care delivery and payment model)</p> <p>Utah Partnership for Value-driven Health Care (community collaborative comprising stakeholders representing health care purchasers, payers, providers, and the public)</p> <p>At least 10 public and private efforts including ACOs that the Plan characterizes as partial VBP</p> <p>Related to medical homes</p> <p>Federally supported initiatives include CHIPRA quality demonstration, MCH special needs population</p> | <p>General population</p> <p>Related to medical homes</p> <p>Medicaid, especially children</p> <p>CHIPRA</p> <p>Recipients of MCH services</p> <p>Enrollees in private plans</p> <p>Related to ACOs</p> <p>Medicaid and CHIP beneficiaries in four largest counties (70% of total)</p> <p>Enrollees in private plans</p> | <p>Existing</p> <p>SB 180 (2012) allowed Medicaid ACOs</p> <p>Proposed executive branch policy-making and use of existing programs</p> <p>*Use existing budget and authority, and potential requests for authority and budgets, and development of new programs</p> <p>*Voluntary partnership between UDOH, Utah Hospital Association, Utah Medical Association, Health Insight, and Utah Medical Insurance Association to develop consortium for disclosure and resolution training and dissemination and clearinghouse of best practices (p. 99)</p> <p>State facilitation of system change</p> <p>*Providers and payers motivated by market forces to transition to full VBP</p> | <p>UDOH</p> <p>Contracted third party to conduct test</p> <p>private payers and providers</p> <p>[Any Round 2 SIM project, particulars as yet unspecified]</p> |

(continued)

Appendix Table 23A-1. Models and strategies proposed in Utah Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|------------------------|--|-----------------------|--|--|
| | <p>State initiatives include early childhood data integration to federal and state</p> <p>Various private market medical home-like primary care case management initiatives (e.g., Personalized Primary Care at Intermountain Health Care)</p> <p>Related to ACOs</p> <p>Medicaid/CHIP ACOs</p> <p>Private initiatives (e.g., Intermountain Shared Accountability Strategy)</p> | | | |

(continued)

Appendix Table 23A-1. Models and strategies proposed in Utah Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|---|---|---------------------------|--|---|
| <p>End-of-life preferences</p> <p>Increase number of Utah patients who have completed appropriate end-of-life forms by:</p> <p>Developing and enhancing health IT-enabled tools such as an electronic registry for ePOLST and assessing their ability to support increasing the number of Utahns who have completed the appropriate end-of-life forms</p> <p>Teaching providers how to have crucial conversations around end of life, POLST, and advance directives</p> <p>Engage the community in end-of-life conversations</p> | <p>Beacon ePOLST program</p> | <p>General population</p> | <p>Existing legislative authority</p> <p>UDOH to exercise legal authority to adopt standard documents for ePOLST (p. 103)</p> <p>State investment</p> <p>Funding to UDOH, the Leaving Well Coalition, UHIN, and the University of Utah to develop and assess health IT-enabled tools (p. 102)</p> <p>State-led coalition to drive voluntary action</p> <p>*State to partner with consortium of Utah Medical Association, Health Insight, physician leaders, and community organizations to teach providers how to have conversations around end-of-life decisions (p. 102)</p> <p>State facilitation of system change</p> <p>*Voluntary engagement of providers and community (e.g., churches, faith-based organizations, educational systems, legal institutions); Utah Commission on Aging to act as convening organization; Leaving Well Coalition, a community nonprofit organization, to outreach to patients, families, providers, and other interested parties (p. 103)</p> | <p>UDOH</p> <p>UHIN</p> <p>physician leaders</p> <p>community organizations</p> <p>Utah Commission on Aging</p> <p>Leaving Well Coalition</p> <p>University of Utah</p> |

(continued)

Appendix Table 23A-1. Models and strategies proposed in Utah Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|---|---|--|---|---|
| <p>Integration of behavioral and primary health care</p> <p>Increase access to and improve primary care and behavioral health services in underserved, rural areas</p> <p>Integrate behavioral health into primary care settings</p> <p>Implement most effective prevention and treatment practices for behavioral health according to the ROSC Continuum Matrix</p> | <p>SAMHSA’s SBIRT model</p> <p>University of Utah’s GATE Program—pilot program for psychiatric consultations in primary care settings</p> | <p>General population, especially those living in areas with poor access to behavioral health services</p> | <p>State investment</p> <p>Funding to partnership of UDOH Emergency Medical Services Bureau, Utah DHS Substance Abuse and Mental Health Bureau, and Utah Department of Commerce Division of Occupational Licensing to train providers to integrate mental, emotional, and behavioral health screenings and interventions using interdisciplinary teams using SBIRT (p. 103)</p> <p>Funding to advocate for expanding mental health and substance abuse screening in the education system (Plan does not specify who is responsible for advocacy) (p. 103)</p> <p>Funding to DHS to implement most effective prevention and treatment practices according to ROSC Continuum Matrix (p. 104)</p> <p>State purchasing contract</p> <p>Funding to DHS, UDOH, and AHEC to place behavioral health providers and training in underserved, rural areas (p. 105)</p> <p>Funding to GATE program to provide behavioral health telehealth services (p. 106)</p> | <p>UDOH</p> <p>UDOH Emergency Medical Services Bureau</p> <p>Utah DHS Substance Abuse and Mental Health Bureau</p> <p>Utah Department of Commerce Division of Occupational Licensing</p> <p>DHS</p> <p>AHEC</p> <p>University of Utah Health Care</p> |

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Appendix Table 23A-1. Models and strategies proposed in Utah Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|--|---|-----------------------|---|--|
| Workforce development Train providers to perform in VBP environment through both workforce education and continuing education Decrease inappropriate use of hospital resources through education of providers and patients about choosing health care interventions wisely Improve communication and reduction of risk and liability: Teach providers on how to have crucial conversations around disclosure and resolution (p. 99) Train physicians, medical directors, liability insurers, risk managers, and existing patient safety officers to lead communication initiatives (p. 99) Develop cross-institutional collaborative for provider communication and learning (p. 100) | UCAP Choosing Wisely Campaign | N/A | State purchasing contract Funding to UCAP to expand initiatives with systems of higher education (p. 98) Funding used to contract Care Management Plus, Health Insight, and other entities to provide training on care management; health promotion; use of IT; collecting and reporting quality metrics, and patient safety event and identification disclosure (p. 99) | UCAP providers of higher education Care Management Plus UDOH Health Insight With regard to improving risk communication and reduction of liability Utah Hospital Association Utah Medical Association healthcare consumers Utah Medical Insurance Association |

(continued)

Appendix Table 23A-1. Models and strategies proposed in Utah Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|---|--|--|--|---|
| <p>Public health strategies</p> <p>Increase proportion of health plans and organizations that engage CHWs</p> <p>Align wellness efforts across public, private, and nonprofit sectors within at least one community around a common agenda to improve community health</p> | <p>Piecemeal public and private use of CHWs, but no systematic program for training, accreditation, or employment</p> <p>Many siloed population health initiatives or programs</p> | <p>General population in at least one community to be selected</p> | <p>Proposed executive branch actions</p> <p>UDOH to promote voluntary adoption of CHWs by payers by collecting data on existing payer commitment to CHWs to create business case for use of CHWS (p. 107)</p> <p>Funding to UDOH to evaluate examples of CHW community linkages in state and select evaluation method for determining how to strengthen CHW community linkages (p. 107)</p> <p>Funding, potentially to CHW association, to implement statewide CHW training curriculum and process (p. 108)</p> <p>UDOH to facilitate adoption of CHWs into individual health systems' care models and evaluate the results of implementing CHW model in four population subsets (p. 108)</p> <p>UDOH to select community and select a "backbone organization" to convene a community coalition and assist it in developing community goals, implementing interventions, and evaluating outcomes (p. 108)</p> | <p>UDOH</p> <p>CHW association (currently in development)</p> <p>selected "backbone organization"</p> |

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23-25

Appendix Table 23A-1. Models and strategies proposed in Utah Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|--|--|-----------------------|---|--|
| <p>Health IT</p> <p>Increase Utah stakeholder use of key health IT-enabled tools to support timely and accurate information for value-based delivery of care and payment reform by:</p> <p>Developing a statewide Master Person Index (p. 93)</p> <p>Providing necessary infrastructure and support to Critical Access Hospitals, Long-Term Care, and Behavioral Health Providers to make the cHIE a viable platform for reporting individual provider metrics and community quality metric benchmarks (p. 93)</p> <p>Enhancing security measures for key health IT-enabled tools</p> <p>Increasing authorized access of cHIE and other health IT-enabled tools to 100% (p. 94)</p> | <p>Medicaid Electronic Health Record Incentive Payment Program</p> <p>Master Person Index Grant</p> <p>Regional Extension Program (Health Insight)</p> <p>Beacon Community Program</p> <p>APCD</p> | <p>N/A</p> | <p>Existing legislative authority and administrative action</p> <p>Utah legislature has authorized UDOH to establish the sMPI, with advice from the Utah Digital Health Service Commission (p. 47)</p> <p>State purchasing contract</p> <p>*UDOH to identify and contract organization to implement and operate the sMPI (p. 93)</p> <p>*UDOH to oversee UHIN and Health Insight in provision of health IT infrastructure and support (p. 93)</p> <p>*Funding to be provided to Health Insight, the Regional Extension Center for health IT in Utah, to conduct community outreach and education and to direct technical assistance; additional funding will be given to various organizations to provide outreach and technical assistance to clinics and facilities (p. 94)</p> | <p>UDOH</p> <p>Utah Digital Health Services Commission</p> <p>Health Insight</p> <p>UHIN</p> <p>technical assistance contractors</p> <p>Utah Medical Association</p> <p>Health Insight</p> |

(continued)

Appendix Table 23A-1. Models and strategies proposed in Utah Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|---|--|-----------------------|--|---|
| Validate that all authorized users of key health IT-enabled tools have completed appropriate HIPAA and other security training (p. 72) | | | | |
| <p>Enhanced data analysis</p> Create a set of statewide outcome metrics that can be used to determine value in health care, which can be measured by data collected from payers (p. 95) Create capacity within APCD to become the sole source of value metrics for all providers and payers (p. 96) Provide technical support to individuals, small business, and public health to ensure ability to use VBP data and to ensure that new care coordination, case management, and care transitions codes are fully used (p. 97) | Medicaid/CHIP ACOs (measures used by the Utah Medicaid ACOs may serve as basis for development of statewide metrics) | N/A | <p>State facilitation of system change</p> *UDOH will contract third party to convene stakeholders for discussion of value metrics and adoption through consensus (p. 96) *Volunteer participation by payers and providers in VBP test <p>Proposed executive branch action</p> APCD team at UDOH to implement changes to APCD (p. 96) <p>State purchasing contract</p> *UDOH to contract third party to provide technical assistance to providers on using VBP data and new care coordination, case management, and care transitions codes (p. 97) *UDOH to contract third-party organization to conduct VBP test (p. 96) Funding to UMEC to expand workforce surveillance strategies (p. 97) | UDOH Health Insight UMEC (workforce surveillance) |

(continued)

Appendix Table 23A-1. Models and strategies proposed in Utah Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|---|---|-----------------------|--|--|
| Generate and disseminate information on effectiveness of VBP model by conducting test comparing at least three VBP systems in voluntarily recruited payers and providers and reporting results (p. 96) Develop workforce projections and surveillance for VBP environments: Expand surveillance to include primary and behavioral providers working in team and VBP environments Incorporate population needs and outcomes into supply model of providers in a VBP environment | | | | |

¹Policy levers include Medicaid waivers; federal grants (including Round 2 SIM award); state laws; state regulations; state investments (e.g., in public health programming); foundation grants; employer-led coalitions to drive change among providers, purchasers, or plans; state government-led coalitions, task forces, or commissions to drive voluntary change among providers, purchasers, or plans; state purchasing contracts; and state-level (Governor-initiated) executive policy directives.

Abbreviations: ACO = Accountable Care Organization, AHEC = Area Health Education Center, APCD = all payer claims database, cHIE = clinical Health Information Exchange, CHIPRA = Children’s Health Insurance Program Reauthorization Act, CHW = Community Health Worker, DHS = Department of Human Services, GATE = Giving Access to Everyone, HIPAA = Health Insurance Portability and Accountability Act, IT = information technology, MCH = Maternal and Child Health, N/A = not applicable, POLST = Physician Orders for Life Sustaining Treatment, ROSC = Recovery Oriented System of Care, SAMHSA = Substance Abuse and Mental Health Services Administration, SBIRT = Screening, Brief Intervention and Referral to Treatment, sMPI = statewide Master Patient Index, UCAP = Utah Cluster Acceleration Partnership, UDOH = Utah Department of Health, UHIN = Utah Health Information Network, UMEC = Utah Medical Education Council, VBP = Value-based purchasing or value-based payment

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24. Washington

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Washington has a history of engaging in health system reform and several federal and state initiatives under way. Washington initially submitted a proposal for a State Innovation Models (SIM) Model Test award in 2012, but received a SIM Model Pre-Test award instead. In part because of a change in governorship, the state opted to use the SIM Model Pre-Test award as an opportunity to develop a broad Health Care Innovation Plan (the Plan) that builds upon but is significantly more far reaching than the 2012 Model Test application proposed. The planning process was directed by the Washington State Health Care Authority, which engaged a wide range of payer, provider, and community stakeholders through site visits, one-on-one meetings, Webinars, and public comment on draft materials. The Authority also made extensive use of contractors with a history of working with the state to flesh out sections of the Plan. The work of some consultants, particularly the Puget Sound Health Alliance (the Alliance), which convened a group of 50 “thought leaders,” was particularly important in shaping Plan content.

The Plan encompasses mechanisms to spread effective payment and care delivery models that move to outcomes-based payment—including multiple initiatives on prevention and wellness, quality improvement, chronic care management, and integration of physical and behavioral health care. In particular, the state intends to leverage its purchasing power through Medicaid and its state employees’ plan to act as a “first mover” and move the state’s health care market—characterized by strong competition among a few large health insurers—in the direction of greater transparency and improved quality. The state proposes to take a regional approach to procurement, and to contract with Accountable Risk-Bearing Entities that have the capacity to assume full financial risk for physical and behavioral health and services of a population. The state also proposes to develop locally governed, public-private collaboratives called Accountable Communities of Health to support its activities. The Plan is projected to reach 80 percent of those with state-funded and 50 percent of those with commercial coverage by 2017.

24.1 Context for Health Care Innovation

Washington has a long history of health reform to improve coverage, quality, and value, with abundant activities in the public and private sectors. Currently, a number of federal initiatives are under way, including the State Demonstration to Integrate Care for Dual Eligible Individuals, the Medicare Shared Savings Program, and the Federally Qualified Health Center Advanced Primary Care Practice Demonstration (SHADAC, 2012). State agencies, payers, providers, and other entities are also pursuing several pilots and projects related to medical homes, chronic care management, primary care, quality improvement, and performance

measurement. There is an active, “fiercely competitive” (Washington State, December 2013) commercial market that engages in payment and delivery system reform initiatives. Some of these include more than one payer but most are undertaken separately. Despite so much activity, there are few actual outcomes-based payment approaches. The delivery system for people with chronic diseases, particularly for patients with physical and behavioral comorbidities, is fragmented, as are the funding streams for these services. But there are increasing examples of local delivery and payment innovations and a culture that values community-based efforts.

Many of the existing state-led initiatives were first promulgated under the previous Governor, who held health system transformation as a centerpiece of her tenure. It was also during her administration that the state first applied for a Model Test award in late 2012. In response, Washington was awarded Pre-Test funds to create a plan that would: (1) affect a larger proportion of the population, (2) clarify a vision for payment and delivery reform, and (3) better leverage public and community health initiatives (Puget Sound Health Alliance, August 2013). Work began in April 2013 under the administration of the new Governor, who had taken office in January. In late 2012, leadership of the state senate also changed.

With the new Governor also prioritizing health care in his administration, one stakeholder commented that there was “no whiplash effect,” as the Governor and his staff picked up the mantle of Plan development. The new staff were able to benefit from the groundwork of the previous administration and many individuals involved with development of the initial application were brought in as consultants and stakeholders to advise on the Plan.

Washington recognizes the potential import of its role as the health care purchaser for nearly a quarter of the population through either Medicaid or the Public Employee Benefit Plan, a figure that will continue to rise as more individuals access coverage under the Patient Protection and Affordable Care Act’s (ACA’s) Medicaid expansion (Washington State, December 2013). On the commercial side, Washington hosts a very competitive market where three of the 61 licensed or registered carriers in the state—Premera Blue Cross, Regence Blue Shield, and the Group Health Cooperative—dominate with 80 percent of the market (Washington State, December 2013). Some stakeholders commented that the state has an environment in which incentives seem to reward competition rather than coordination and transparency—an issue the state would continually contend with in any Plan implementation.

Overall, Washington’s population boasts slightly above average performance on such health indicators as self-reported health status and life expectancy; however, concern about rates of chronic disease persists, particularly in regard to health disparities faced by low-income individuals and American Indians (Washington State, December 2013), whose tribal communities constitute nearly 2 percent of the state’s population (United States Census Bureau, 2014). Washington has also identified some critical needs for improvement in care and

treatment for individuals with behavioral health issues, including improved integration across physical and behavioral health services and clear accountability to achieve better outcomes.

24.2 Planning Infrastructure and Process

The incoming administration took the opportunity presented by the Pre-Test award to restart the entire planning process and develop a much broader plan. A core team of staff from the Health Care Authority, with oversight from both an informal and a formal multi-agency leadership structure, used a wide range of consultants to inform the planning process. Washington worked with stakeholders across the state in a variety of ways, including site visits, one-on-one meetings, and public Webinars. The Alliance was a particularly important convener of stakeholders, although some interviewees raised concerns about the methods of engagement the Alliance used—particularly about how the state engaged both payers and American Indian tribes, concerns the state has reportedly worked to address.

Governance and management. The state’s receipt of a Pre-Test award coincided with the beginning of the incoming Governor’s tenure. State officials indicated that, although development of the Plan offered “a good chance to recalibrate,” there was a high degree of continuity between the previous and current Governors regarding priorities related to health care policy. The current Governor has adopted Plan implementation as a major governing priority, and his office has been very engaged in the effort. In addition, the Governor collaborated with the Washington Business Roundtable, a policy organization of senior private sector executives, to convene a group of CEOs and major purchasers in the state and engage them on the need for delivery and payment reform. The state legislature, though not involved in either development of the Plan or the stakeholder engagement process, in early 2014 passed two pieces of legislation that would facilitate implementation of pieces of the Plan.

Development of the Plan was led from the Washington State Health Care Authority, which oversees the state’s Medicaid program, by a core group of five staff. The core group is led by a contract project director brought on to oversee Plan development and stakeholder engagement. Cabinet-level engagement in Plan development was robust. An informal cross-agency “Kitchen Cabinet”—made up of the Governor’s health policy advisor and senior staff from the Departments of Health, Social and Health Services, and Labor and Industries; Medicaid; Office of Financial Management; Public Employees Benefits Board; and Washington State Health Benefit Exchange—met monthly to coordinate strategy and to ensure the Plan was consistent with the Governor’s priorities. A formal Executive Management Advisory Council (EMAC) also oversaw the major elements and structure of the Plan. The EMAC met four times during the course of the planning and included many of the agencies in the Kitchen Cabinet, plus the Departments of Commerce and Early Learning, the Insurance Commissioner, the Office

of the Superintendent for Public Instruction, and the State Board of Community and Technical Colleges. Portions of the Plan were drafted by Kitchen Cabinet and EMAC members.

Consultants. Washington made extensive use of consultants and partners to carry out aspects of Plan development. The work of many of the nine consulting groups—each of which was responsible for a different element of the Plan—included reaching out to stakeholders through interviews, one-on-one meetings, and larger meetings. Manatt Health Solutions, for example, performed an analysis of the current behavioral health landscape to inform portions of the Plan regarding behavioral health integration. The Robert Bree Collaborative, a statewide public-private consortium, helped develop the Plan’s approach to evidence-based purchasing. And the Alliance reached out to stakeholders through both the group of thought leaders it had convened (described below) and a series of public webinars.

Consultants were funded mainly through the Pre-Test award, but the state did receive external support for the work of several consultants. The Bill and Melinda Gates Foundation funded the Cedar River Group to help develop the portions of the Plan related to social determinants of health. (Stakeholders did not specifically comment on the effect this foundation-funded research had on the final Plan.) The National Governors Association supported a 40-person workforce summit in September to set priorities in meeting health workforce needs (National Governors Association, September 2013). And the Empire Health Foundation and Robert Bree Collaborative provided support for developing the state’s initial Model Test application in 2012.

Stakeholder engagement. Washington reported engaging a wide range of provider, payer, consumer, and community stakeholders during its Plan development process. The state maintained a 750-member “Feedback Network,” including an email list for distributing notices of meetings and draft materials. More than 900 people attended the four public webinars held by the Alliance (October Quarterly Progress Report), and more than 100 submitted comments on a draft preliminary outline of the Plan, which was made available in fall 2013 for public review. The SIM Initiative director and other state staff made several site visits to locations across the state to learn from innovative local initiatives, such as a Kitsap County project on bidirectional integration of behavioral health services. The SIM Initiative director also went on a “road show” to locations across the state to hold one-on-one meetings with local constituencies. Many stakeholders expressed positive opinions about their level of access to the SIM Initiative director.

Many stakeholders identified the group of 50 thought leaders convened by the Alliance as a key source of ideas that were incorporated into the Plan, yet several stakeholders identified problems with this method of stakeholder engagement. First, it was unclear to many stakeholders exactly how individuals were selected for participation in the thought leader group. Second, stakeholders indicated that, although the right individuals may have been involved in the conversation, *how* they were involved may create some issues for implementation. As one

stakeholder put it, the Alliance’s instructions to thought leaders were “When you come in the door, take off your stakeholder hat, put on your ‘think about health care’ hat.” While this approach enabled stakeholders to engage in a broad conceptualization of an improved health care system in Washington as thought leaders, some interviewees indicated that this focus on developing broad concepts—rather than on making specific requests for commitment from stakeholders on behalf of their organizations—may limit the amount of buy-in those organizations feel toward the Plan. Interviewees thought this was particularly applicable to payers who took part in the thought leader group.

American Indian tribes were a key group that felt neglected during most of the Plan development period. Tribal officials reported feeling entirely left out of the planning process and were very concerned about the effects the state’s proposed payment redesign strategies—particularly its proposed regional approach—might have on tribes. Between our stakeholder interviews (in November) and publication of the Plan, state officials worked to improve their consultation with tribes. The final Plan includes the following quote from the chair of the American Indian Health Commission: “we have appreciated the government-to-government consultation process in the development of the policy” (Washington State, December 2013).

Finally, some stakeholders expressed concern about a perceived low level of engagement of local health departments in developing the regionally based strategies proposed in the Plan. Those stakeholders expressed fear that the regionalization proposed in the Plan might increase competition for limited resources.

24.3 The Washington Plan

The Plan aims to improve individual and population health through a series of strategies to promote multi-payer adoption of value-based purchasing, build healthy communities focused on prevention, and improve integration of care and social supports. Details of how the Plan is to be implemented will unfold over the next year and be heavily informed and affected by new geographically based communities set up throughout the state. The state itself would also serve as a driver for reforms through its role as a purchaser and, as necessary, regulator. There is consensus among stakeholders that at least one of the proposed strategies would “touch” the majority of the state, although skepticism remains over the overall ability of the Plan to drive health system improvements.

24.3.1 Models and Strategies

The Plan centers around three distinct yet interrelated strategies developed out of Washington’s planning process: (1) to drive value-based purchasing across the community, (2) to improve health overall by building healthy communities through prevention and early mitigation of disease, and (3) to improve chronic illness care through better integration of care and social

supports. Also woven throughout the Plan are strategies to enhance integration of physical and behavioral health—including a commitment to full integration of physical and behavioral health purchasing in Medicaid by 2019, greater community oversight and input on behavioral health contracts and services, improved data accessibility and analytic resources pertaining to patients with behavioral health needs, enhanced practice transformation support specifically targeting behavioral health needs, and expansion of telehealth behavioral health consultation services. [Appendix Table 24A-1](#) provides a summary description of the innovations proposed in each category, initiatives on which they are built, populations they address, and supporting policy levers and entities.

Value-based payment methods. The Plan describes statewide movement toward use of value-based payment methods, committing the state to using value-based payment methods for 80 percent of state-financed health care within 5 years. Once ACA provisions are implemented, it is anticipated that nearly one-third of Washington’s population will be covered under the state’s Medicaid and Public Employee Benefit programs, meaning the state wields significant power to drive widespread reforms just by adapting payment models for these programs alone. Specifically, the Plan proposes that the state implement a new regional procurement strategy to incentivize patient-centered primary care and coordinated delivery systems. No more than nine regional service areas would be identified, with the goal of improving alignment of service areas across current state programs—including those run by the Department of Social and Health Services, Department of Labor, Health Care Authority, and Department of Early Learning. Boundaries of the regions for Medicaid purchasing would correspond with boundaries defined for Accountable Communities of Health (described below). Each Accountable Community of Health within a region would be enabled to set objectives for Medicaid procurement that would encompass regional needs and perspectives. This would, in part, be accomplished through Medicaid contracts with Accountable Risk-Bearing Entities, which the Plan defines as “managed care plans, risk-bearing public-private entities, county governmental organizations, or other community-based organizations with a risk-bearing partner or the direct capacity to assume full financial risk” for physical or behavioral health and services of a population (Washington State, December 2013). The state also plans to collaborate with major purchasers to move at least 50 percent of the commercial market to value-based payments in 5 years.

Accountable Communities of Health. The Plan proposes that each regional service area have one locally governed, public-private collaborative called an Accountable Community of Health, which would serve a multifaceted role in addressing community and state-level health priorities. Some of the responsibilities of the Accountable Communities of Health may include, although are not limited to, assessment of requests for proposals (RFPs) from Accountable Risk-Bearing Entities; advising the state on Medicaid procurements; development of a Regional Health Improvement Plan to address community health priorities; and fostering regional coordination and collaboration on compacts, investments, data sharing, and workforce resources.

Accountable Communities of Health would include representation from public health, health, housing, social services, risk-bearing entities, county and local governments, education, philanthropy, consumers, tribes, and any other relevant stakeholders within the Community's region. The state does not intend to dictate the precise organizational structure of each Accountable Community of Health, but will provide funding, technical support, and oversight to the Communities.

Enhanced data analysis and public reporting. The Plan describes data use and transparency as a foundation for transitioning to value-based payment models. Accordingly, underlying many of the Plan's suggested reforms is implementation of methods to enhance data collection, use, and reporting across the state. First, the state would develop a common measure set to evaluate provider performance and progress—including indicators of improved preventive care, chronic disease management, and use of high-value care for acute conditions. To the extent possible, the measure set would build on current measure sets, including nationally endorsed measures (e.g., National Quality Forum), measures used by Washington's HealthPlanFinder (the state's health insurance marketplace), measure requirements for Medicaid delivery systems, and specifications developed by thought leaders convened by the Alliance during the Plan development process. The Plan remains vague on exact methods of data collection, although options include reporting through the state's planned all-payer claims database (APCD) or modifications to data already required from payers participating in the HealthPlanFinder.

Data collected from the statewide measure set would be available to all stakeholders, including purchasers, providers, communities, and consumers. Analyses would be conducted and shared to identify and recognize providers and health systems delivering efficient, high-quality care, and identify unnecessary variation in care and other opportunities to improve quality of care and reduce cost. Cost and quality reports for consumers would be culturally appropriate, in plain language, and at a summary level. Additionally, the state would partner with the University of Washington Institute for Health Metrics and Evaluation to develop a "toolbox" of data capabilities and technical assistance resources to support population health analytics and enable targeted health interventions. The toolbox would include a new Geographic Information System mapping system. Lastly, Washington would build the planned APCD, expanding its multi-payer database using federal funds received in 2013.

Delivery system transformation resources and support. To support practices transitioning to new delivery models—including patient-centered medical homes, accountable care organizations, or other modified models—Washington would create a Transformation Support Regional Extension Service (Extension Service) that would serve as a statewide hub for tools, resources, and infrastructure support for practice transformation, including quality improvement, delivery system redesign and integration, and person-centered care. At the state level, the Extension Service would convene and coordinate all Plan transformation support

initiatives and resources. Agents of the Extension Service would be housed within Accountable Communities of Health to provide community-level support.

In addition, Washington would advance use of shared decision-making tools through state development and certification of decision aids. The state would also coordinate with state-financed contractors to implement various tools available through local and national organizations—including the Informed Medical Decisions Foundation Maternity Care Shared Decision Making Initiative, Dr. Robert Bree Collaborative, and American Board of Internal Medicine Foundation’s Choosing Wisely campaign.

Workforce development. The state recognizes that reforms described in the Plan must be supported by an adequate workforce of health care and other related professionals. The Plan, therefore, proposes further exploration of several tactics to retain and extend workforce capacity within the state. Many of these tactics center around improvements in education and training for both current and future professionals—such as education and training to support cultural competency, use of telemedicine, and team-based and whole-person care, as well as incentives (e.g., loan repayment programs, sustained Graduate Medical Education funding) to support an enhanced supply of primary care physicians, advanced registered nurse practitioners, and physician assistants. The Plan also suggests improved engagement, training, and utilization of various health and social service providers in new integrated care systems, including community health workers, psychiatrists, pharmacists, and advanced registered nurse practitioners. Other tactics include regulatory changes to reimbursement practices to drive more efficient use and reach of the current workforce, such as modified reimbursement structures for telehealth and nondispensing pharmacy services.

24.3.2 Policy Levers

This section discusses the main policy levers discussed in the Plan. *Appendix Table 24A-1* provides a summary description of these and other potential regulatory, executive branch, and voluntary actions the state may pursue to support facets of the Plan, including the initiatives on which they are built, populations they address, and supporting policy levers and entities.

The Plan speaks generally about the policy levers that would be used to implement the proposed models. Work over the upcoming year is to largely focus on development of these details, with many decisions left to the various communities (e.g., Accountable Communities of Health, Accountable Risk-Bearing Entities) established by the state as proposed by the Plan. However, critical to the state’s overall approach are plans to leverage its role as “first mover” to drive value-based purchasing through a requirement that 80 percent of all state-financed health care use value-based payment methods, with additional requirements to encourage use of reference pricing and tiered/narrowed networks for state-financed health care. In June 2014, the

state proposes to release a request for information and baseline requirements for implementation of Accountable Communities of Health. New regional service areas for Medicaid procurement are proposed to be established in September 2014.

The Plan includes several proposed or in-process levers specifically intended to support implementation of portions of the Plan. In early 2014, the legislature passed two pieces of legislation—HB 2572 and SB 6312—that enact certain Plan provisions. With regard to data analysis and reporting, HB 2572 provides for establishment of a statewide APCD to support public reporting of health care information and creation of a performance measures committee to identify standard statewide measures of health performance. The Plan further proposes requirements for cost calculators in all state health plan procurement contracts. With regard to delivery system transformation, HB 2572 provides authorization and financing for two community of health pilots, and support to foster integration of physical and behavioral health. SB 6312 provides a mandate for integrated physical and behavioral health purchasing options for Medicaid coverage beginning April 1, 2016; shared-savings incentives for regions to adopt fully integrated models by January 1, 2016; and requires the development of recommendations for strategies to move toward full integration of medical and behavioral health services by January 1, 2020. Related to workforce improvements, the state proposes to enhance reimbursement rates for telehealth-enabled care and other emerging technologies for home telemonitoring. Washington also proposes to develop guidelines on scope of practice, qualifications, and reimbursement for community health workers. Finally, the state proposes to develop and certify decision-making tools for providers.

24.3.3 Intended Impact of the Health Care Innovation Plan

The Plan proposes many strategies that, combined, are intended to affect the majority of the state. Stakeholders shared mixed reactions to this, claiming the likelihood of the Plan touching most (80 percent) of the state’s population “a stretch, but possible,” especially considering that the strategies are multifaceted and would likely “blanket the state.” The Plan designates specific goals for payment reform strategies to reach 80 percent of those receiving state-funded coverage, and 50 percent of those in the commercial market by 2017, although adoption rates would vary ultimately by commercial payer buy-in and adoption of new payment models. Timeframe would also affect reach, with a few stakeholders suggesting that it would take several years to adequately build the relationships and infrastructure needed to advance proposed reforms in both public and private sectors, and for results to be seen across the majority of the population—especially because not all are frequent users of health care. In fact, stakeholders describe greatest effects as likely to be seen in populations of specific interest to the state, including high health care utilizers, individuals with chronic disease, and individuals with behavioral health issues.

24.4 Discussion

Development of the Plan was largely driven by critical contextual factors in the state, including core stakeholder groups, insurance market composition and competition, and consideration for current policies and programs. These factors led to development of a broad, multisector Plan that articulates a clear vision for improving health in the state.

24.4.1 Critical Factors Shaping the Plan

Three critical factors shaping the Plan were described as: (1) the existing policy and programmatic context, especially in relation to the large number of ongoing initiatives that the state was involved in; (2) the fiercely competitive environment among health insurance companies in the state; and (3) the core stakeholders and consultants who were most influential in contributing ideas and content to the Plan.

The Plan is described as one more step in a long history of innovation in the state, and as necessarily shaped by all the preexisting efforts being undertaken in the state to improve quality and provision of appropriate services. One state official characterized the Plan's relationship to existing activities such as the Alliance, the Bree Collaborative, the Health Technology Assessment Program, and the behavioral health integration projects in places such as Kitsap County this way: “[A] lot of the goal of the SIM plan is to bring that stuff up to scale and to give us the ability to really work more effectively across public and private sectors [...] If we do this right, the goal is to have those kinds of creative initiatives, that have been able to use grant funds to make them happen, is to figure out how through Medicaid procurement we can encourage and institutionalize those practices at the clinical level.”

One widely agreed challenge in bringing elements of the Plan to scale is the competitive environment among health insurers. The development of the “state as first mover” strategy was directly tied to a perception that health plans would not cooperate on common approaches without the state using its leverage as a purchaser to set goals for the entire market. Even with this strategy, stakeholders expressed widespread ambivalence about the extent to which health plans are ready and willing to work together, especially those with notable market share.

The final Plan states that, “The collaborative and inclusive state Innovation Planning process recognized the importance of the contributions of and commitment from all state actors. As such, the Innovation Plan is intended to be viewed as a comprehensive state plan, and not just the state or Governor’s plan” (Washington State, December 2013, p. ii). Although many stakeholders praised the level of access they had to SIM Initiative staff, there was a clear sense that the Plan was heavily shaped by a core, or “insider,” set of stakeholders and consultants, and that it was difficult for individuals and groups not included in that core to have their ideas fully incorporated into the Plan. This was partly attributed to the fast timeframe for the planning

process; the process—even with the extension the state was granted—was widely seen as too compressed to cultivate buy-in, and several stakeholders indicated that additional outreach will be needed in future months to advance the Plan.

24.4.2 Lessons Learned

Washington’s experience in the SIM Model Design Initiative yields several lessons:

- **There are advantages and disadvantages to developing a broad, multisector Plan.** The Plan envisions health improvement strategies being carried out across a very wide range of programs and activities—not just clinical care settings and public health efforts, but also social support services. This allows the state to articulate a vision for unifying a fragmented system and reaching a preponderance of the state’s population. But adopting such a broad approach makes it harder to include all relevant players, and to meaningfully take their viewpoints into account, particularly in an expedited planning process. This breadth also contributed to a sense among stakeholders that the final strategies adopted in the Plan did not emerge until fairly late in the process. In addition, some stakeholders expressed that they would have preferred a Plan that focused “on a limited number of things and go deep on those things to actually make a difference, rather than [be] a mile wide and an inch deep.”
- **The state can use its leverage as a “first mover” to build momentum.** Particularly given the state’s competitive health insurance environment, stakeholders felt it made sense for Washington to use Medicaid and state employee contracts to set goals that would move the entire marketplace in the state’s desired direction. As one stakeholder put it, “You try to lead with what you can control. It will be hard enough to control the revenue sources and buy-in and management of entities to do this effort together. It [would have been] a lot harder if we had started out as a diffused effort that included private payers with a frontal role of implementation.”

24.4.3 Potential for Implementation

Noting general movement across the state toward many of the reforms suggested by the Plan, stakeholders shared some optimism about the potential for implementation of at least some of its elements. However, pragmatic factors, including stakeholder politics and competition, accountability structures, and availability of resources, were seen to pose real barriers to implementation. As one stakeholder described it, “When you talk about things, you get everyone at the table, but when you start to *do* it, people think about their own interests.”

For example, an issue of concern for stakeholders was statewide movement toward aligned value-based payment reforms. Citing prior attempts to promote payment reform, one stakeholder said that, although it is easy to get people on board with the general concept of advancing payment reforms, “no one [gets] how hard it is,” especially when attempting to bring private and public interests together. Several stakeholders expressed concern that the state may not have done the right kind of “stakeholdering” to secure commitment to the ideas in the Plan.

“It’s that step between ‘what should we do?’ and ‘how are we going to do it?’.... In the end, if you really want to make something happen, you need to engage stakeholders in *how* you’re going to do it.” Although the state brings important leverage and resources to move forward with reforms—including ability to act as “first mover” and to convene groups without antitrust breach—many payers, purchasers, and providers have already begun to explore and move down the path of implementing their own independent payment and delivery reform models, and existing work and priorities may conflict with goals set forth by the state.

While acknowledging the potential of Accountable Communities of Health to drive regional and community-level transformation, multiple stakeholders raised concerns about the feasibility of implementing Accountable Communities of Health that are truly accountable, and effective in responding, to community needs. Specific issues raised include mixed dynamics and existing relationships of various community-level organizations; adequate buy-in and involvement of stakeholders representing unique community-level interests, individuals with complex health needs, and supports beyond traditional health organizations; and clarity about the differences in the roles and responsibilities of the Accountable Communities of Health vs. Accountable Risk-Bearing Entities. One stakeholder questioned the value of the approach, observing that these kinds of processes tend to add an administrative layer that is not necessarily valuable and could be costly.

Finally, several stakeholders noted concerns about the availability of funding to provide sufficient support for the ambitious reforms proposed by the Plan. With effects of the recent recession still reverberating in the state, leadership will be challenged, according to stakeholders, to provide adequate data to its legislature on return on investment. If the state does not receive anticipated federal funding, interviewees said it will likely develop a more incremental strategy for Plan implementation. Regardless, several stakeholders expressed confidence that at least some of the Plan’s reforms would move forward in the near future.

24.4.4 Applicability to Other States

States may opt to explore some of the broad goals and strategies proposed by the Plan, but the few details in the Plan, particularly on implementation of the Accountable Communities of Health, may limit the ability of other states to properly assess how the Plan may be adapted for their own state’s needs. Washington’s Plan was developed in response to several contextual factors affecting the state. As such, it will likely best be adapted in a state sharing a similar health care landscape. As one stakeholder described, the state has done well “in part,... because [it] had [things] to build off of. For a state that doesn’t have the building blocks that we’ve had, it would be a challenge.”

24.4.5 Influence of Pre-Test Status

As noted, Washington essentially started over in designing its Health Care Innovation Plan and as a result, it was quite like other Model Design states. Its long history of reform influenced its process and Plan design arguably more than any special status, although that history and set of activities predisposed the state to initially apply for a Model Test award. More than one state official commented that, if anything, being a Pre-Test state hurt it with respect to resources. Officials believed that under a Model Design award, they would have been able to apply for up to \$2 million rather than the \$1 million received for their Pre-Test award.

24.4.6 Limitations of This Evaluation

Washington submitted its final Plan on January 29, 2014. All stakeholder interviews were completed prior to release of the draft and final Plans, so may not accurately reflect stakeholders' opinions of the final version.

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Appendix Table 24A-1. Models and strategies proposed in Washington Health Care Innovation Plan

| Model type or strategy | Preexisting model, program, or initiative that Plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|--|--|--|--|--|
| Value-based payment methods Statewide movement from fee-for-service toward value-based payment systems | Primary: State-financed health care recipients (Medicaid, state employees) Secondary: Commercial insurance recipients if/when plans adopt value-based payment | State legislative action Require integrated physical and behavioral health purchasing options for Medicaid (see Delivery system transformation resources and support below; enacted, SB 6312) Proposed state executive branch actions *Require 80% of all state-financed health care to use value-based payment methods (in process) *Restructure Medicaid procurement into regional service areas *Use of reference pricing, and tiered/narrowed networks for state-financed health care (2016) State facilitation of system change Adoption of value-based payments by 50% of the commercial market within 5 years | Public Employee Benefits program, Medicaid, entities contracting with the state, providers | |

(continued)

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Appendix Table 24A-1. Models and strategies proposed in Washington Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that Plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|--|---|--|--|--|
| <p>Accountable Communities of Health Regionally governed, public-private collaboratives. ACHs will: Assess RFPs from potential Accountable Risk-Bearing Entities and oversee them Advise the state regarding Medicaid Procurement Develop a Regional Health Improvement Plan Coordinate compacts across service providers to meet goals of the Regional Health Improvement Plan</p> | | <p>Primary: Local communities, Medicaid beneficiaries (ACHs are responsible for Medicaid procurement) Secondary: Individuals with complex health needs</p> | <p>State legislative action *Passed enabling legislation for the creation of two community of health pilots (enacted, HB 2572) Proposed state regulatory action Development and application of conflict of interest policies to exclude bidder involvement or self-dealing Proposed state executive branch action *Release RFI and baseline requirements for implementation of ACHs—three ACHs are proposed to be certified by January 2015 (June 2014) Potential executive branch action Cultivation of transformation support tools though regional and statewide resources, such as learning collaboratives (August 2014)</p> | <p>Public health, health, housing, and social services providers, risk-bearing entities, county and local governments, education, philanthropic partners, consumers, tribes, Medicaid, HIE</p> |
| <p>Serve as a forum to streamline regional activities, foster negotiations of cross-sector investments, and accelerate new delivery and payment model Mobilize and communicate data analytics to communities Foster integration of HIE efforts Facilitate workforce resource sharing</p> | | | | |

(continued)

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Appendix Table 24A-1. Models and strategies proposed in Washington Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that Plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|---|---|-----------------------|--|--|
| Enhanced data analysis and public reporting Development of a common, statewide measures set Construction of a state APCD Creation of a toolbox of data, capabilities, and technical assistance including a new Geographic Information System mapping system | | N/A | State legislative action * Establishment of a statewide APCD (enacted, HB 2572) * Creation of a performance measures committee to identify standard statewide measures of health performance (enacted, HB 2572) Proposed legislative action * Standardize definitions for common procedures and services (e.g., episodes of care) (April 2014) Proposed executive branch action * Requirement for health plan cost calculators in state procurement contracts (October 2014) * Requirements for all providers of state-financed health care to collect and report common measures (April 2014) | Payers, providers, purchasers, Washington HealthPlanFinder, University of Washington, ACHs |

(continued)

Appendix Table 24A-1. Models and strategies proposed in Washington Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that Plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|------------------------|---|-----------------------|---|--|
| | Analytics role existing within local health jurisdictions (e.g., Homeless Management Information System data, jail health data, crisis system data, emergency medical services data, and housing data); Public/Private Transformation Action Strategy, Washington HealthPlanFinder; Governor’s performance management system measures; measure requirements in State House Bill 1519; disease registries, Institute for Health Metrics and Evaluation | | State facilitation of system change Qualified Health Plan submission of quality data to Washington HealthPlanFinder (October 2015) Payer submission of data to the APCD (2015) | |

(continued)

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Appendix Table 24A-1. Models and strategies proposed in Washington Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that Plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|--|---|---|--|--|
| <p>Delivery system transformation resources and support</p> <p>Creation of the Transformation Support Regional Extension Service to serve as a tools and resources clearinghouse for community-based practice support</p> <p>Enhanced shared decision-making tools and resources</p> <p>Incentives to promote integration of physical and behavioral health</p> | <p>Informed Medical Decisions Foundation Maternity Care Shared Decision-Making Initiative; Dr. Robert Bree Collaborative; the American Board of Internal Medicine Foundation’s Choosing Wisely campaign; Edward Wagner’s Chronic Care Model</p> | <p>Regional/local communities, particularly residents who interact with multiple community services (health, housing, transportation, jails)</p> <p>Indirectly affects any resident affected by a public or private practice transformation effort</p> <p>Primary: Maternity care patients; then, shared decision making to expand to other sensitive care areas and focus areas of the Bree Collaborative: end-of-life care, joint replacement</p> <p>Chronic care patients, particularly those with physical and behavioral comorbidities</p> | <p>Proposed executive branch action</p> <p>*Develop and certify provider decision-making tools</p> <p>Require state-financed contractors to use maternity decision aids (January 2015)</p> <p>Establish Extension Service advisory board (January 2015)</p> <p>State legislative action</p> <p>Establish a health extension program to provide training, tools, and technical assistance to primary care, behavioral health, and other providers with emphasis on high quality, comprehensive, evidence-based care (enacted, SB 6312)</p> <p>*Enable support for integrated behavioral and physical health services through Medicaid managed care procurements (enacted, SB 6312)</p> <p>*Mandate for integrated physical and behavioral health purchasing options for Medicaid coverage in 2016 (enacted, SB 6312)</p> <p>*Creation of shared-savings incentives for adoption of integrated care models beginning in 2016 (enacted, SB 6312)</p> <p>Develop recommendations for strategies to move toward full integration of medical and behavioral health services by 2020 (enacted, SB 6312)</p> | <p>Providers, consumers, Dr. Robert Bree Collaborative, employers, Informed Medical Decisions Making Initiative, counties, health collaboratives, public health jurisdictions, providers</p> |

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Appendix Table 24A-1. Models and strategies proposed in Washington Health Care Innovation Plan (continued)

| Model type or strategy | Preexisting model, program, or initiative that Plan incorporates or expands | Populations addressed | Policy levers ¹ (*most important, on basis of document review and interviews) | Entities that will be involved in implementation |
|---|---|--|---|---|
| <p>Workforce development</p> <p>Develop better career progression opportunities, including incentives to learn new skills and better incorporate military health providers in Washington’s workforce</p> <p>Enhance training and utilization of CHWs</p> <p>Improved education and practice support focused on team-based care, coordinated care, “whole-person” care, and use of telemedicine</p> <p>Extend workforce capacity through telehealth and telemonitoring</p> <p>Expand primary care residency opportunities</p> <p>Leverage progressive scope of practice laws to enable “top of license” care for providers such as advanced registered nurse practitioners, pharmacists, and nurses</p> <p>Evaluate educational financing opportunities (e.g., loan repayment programs, Graduate Medical Education)</p> | <p>Washington State Workforce Training & Education Health Care Personnel Shortage Task Force, the Washington State Board for Community & Technical Colleges, Community Health College and Innovation at Pacific Tower, interprofessional educational methods used by academic and practice settings, current scope-of-practice laws enabling enhanced roles for advanced registered nurse practitioners and pharmacists</p> | <p>General population, particularly patients with complex needs, patients with physical and behavioral comorbidities</p> | <p>Potential regulatory action</p> <p>Enhance reimbursement for telehealth-enabled care and emerging technology for home telemonitoring</p> <p>Proposed executive branch action</p> <p>Create a workforce team to focus on CHWs and develop a timeline outlining the steps each stakeholder must take to establish an effective CHW workforce (April 2014)</p> <p>Potential executive branch action</p> <p>*Develop guidelines on CHWs scope of practice, qualifications, and reimbursement methods (April 2014)</p> | <p>Department of Health, universities, Transformation Support Regional Extension Service, CHWs, military health providers, registered nurse practitioners, pharmacists, and other providers</p> |

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Appendix Table 24A-1. Models and strategies proposed in Washington Health Care Innovation Plan (continued)

¹ Policy levers include Medicaid waivers; federal grants (including Round 2 SIM award); state laws; state regulations; state investments (e.g., in public health programming); foundation grants; employer-led coalitions to drive change among providers, purchasers, or plans; state government–led coalitions, task forces, or commissions to drive voluntary change among providers, purchasers, or plans; state purchasing contracts; and state-level (Governor-initiated) executive policy directives.

Abbreviations: ACA = Affordable Care Act, ACO = Accountable Care Organization, ACH = Accountable Communities of Health, APCD = all-payer claims database, CHW = community health worker, HIE = health information exchange, N/A = not applicable, RFP = request for proposals.

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