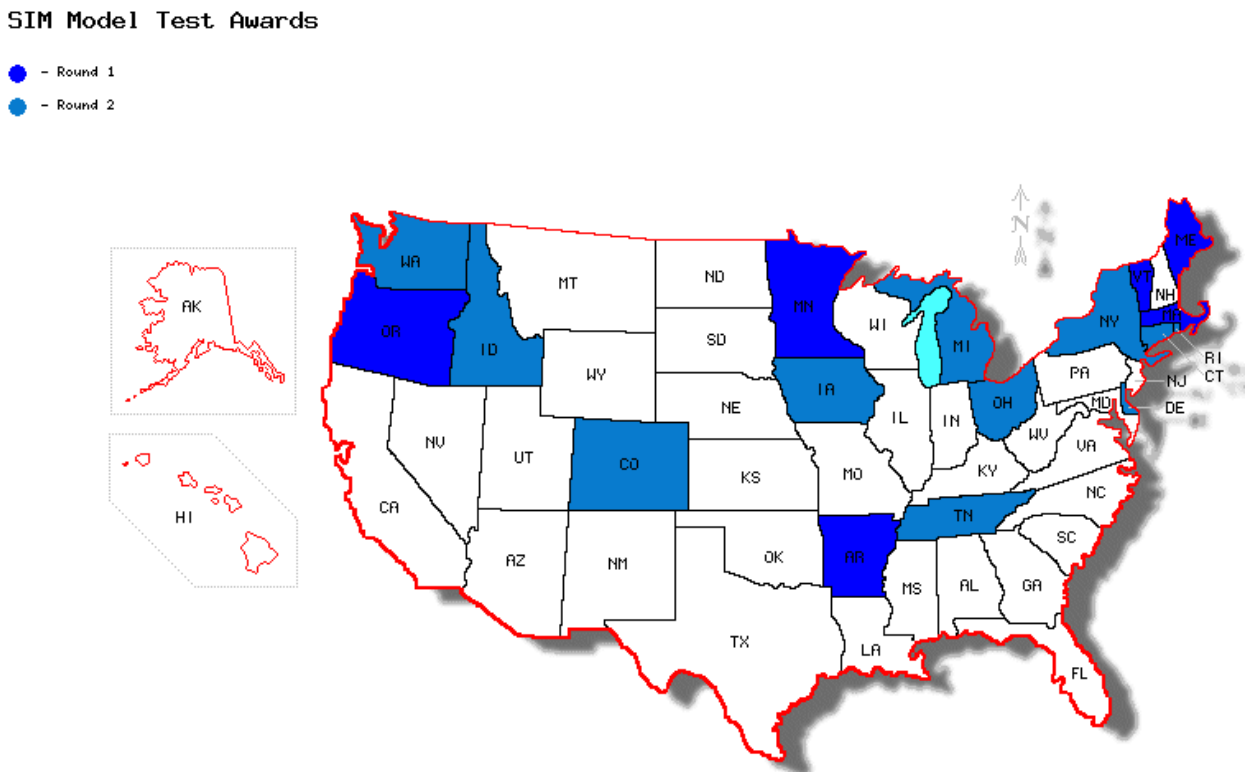
COMMUNITY CATALYST

SIM Round 1 Grant State-Level Summary and Analysis

The Center for Medicare and Medicaid Innovation (CMMI) is currently funding two rounds of State Innovation Model (SIM) test grants. These grants allow state governments to implement approved plans aimed at transforming their health care delivery and payment systems, particularly in regard to their Medicaid programs. In addition to monetary assistance, CMMI will be providing states with expertise and leadership throughout the duration of the grant.



The primary purpose of the SIM grant program is to achieve the "triple aim" of improving care quality, reducing total per capita health care costs and improving the health outcomes for populations. Ideally, the SIM program will cut costs and increase quality, but it would also be a success to either improve quality without increasing costs, or to reduce costs without reducing quality. In addition to this primary goal, the SIM program is designed to promote improvements in state-level health information technology (HIT) infrastructures while supporting improvements in the health professional workforces.

All SIM grants include several common themes—primary among these are payment reform, delivery reform, and infrastructure investment. That said, each state has latitude to design its own

transformation plan (while remaining within the general boundaries set by CMMI), thus there are many differences between different state models.

This resource provides the following: a brief description of each state plan; the themes of different plans; and a summary of initiatives that are common across multiple states.

Round 1 Model Tests

The first round of SIM Model Test grants was approved in February 2013 and included six states: Arkansas, Maine, Massachusetts, Minnesota, Oregon and Vermont. These states received between $33 million and $45 million dollars each (totaling $254.3 million across all six states combined), to run 42 month test implementations of their state health care transformation plans.

Arkansas

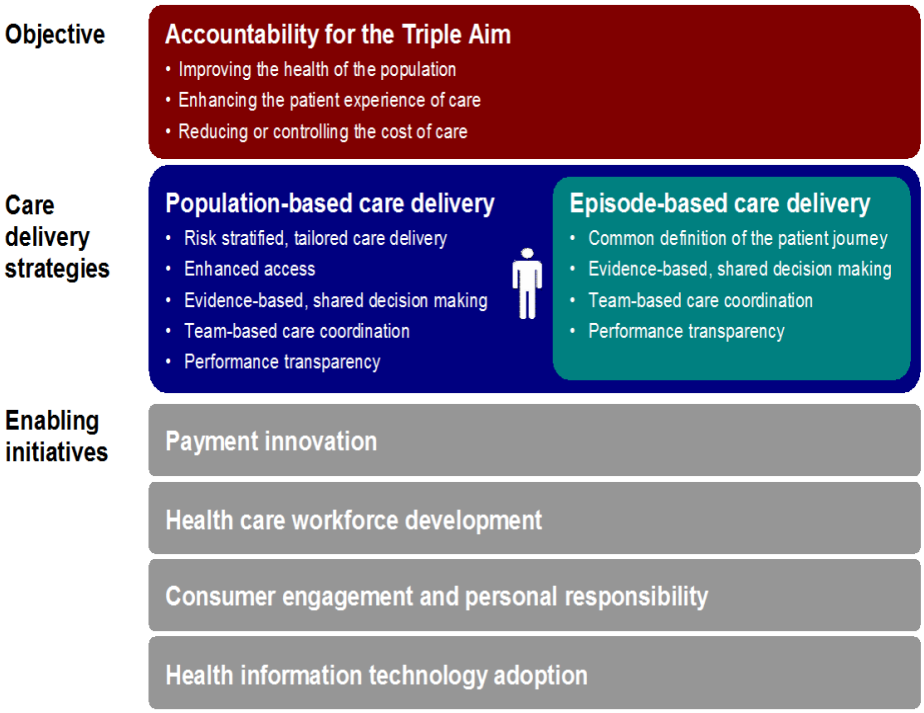
CMMI has awarded Arkansas $42,000,000 to implement its health care transformation plan. The plan involves both public and private payers, and has a focus on promoting "patient responsibility."

Delivery Reform	Payment Reform
Arkansas is implementing a dual system of providers, where **Health Homes** provide integrated care to people with long-term or severe medical needs (ex. super-utilizers, the mentally ill, etc.) while Patient Centered Medical Homes (**PCMH**s) provide episode-based care to individuals with acute or complex medical needs. The transition has been promoted by offering **financial incentives to providers** that contain costs while retaining/increasing quality, as well as offering **technical and logistic support**.	Arkansas plans to insert some pay-for-value characteristics into its state's payer compensation models. Health Home compensation uses a **risk-adjusted formula** that takes into account real costs, expected costs, and health outcomes. **Episode-based care** (a major focus of the reforms) retains a **fee-for service structure**, but it includes **savings-sharing and penalties** based upon a set estimated price for each episode of illness.
Infrastructure	**Other**
Arkansas is using SIM funds to establish an **all-payer claims database**, fund improvements to provider broadband infrastructure, and improve its electronic medical record **(EMR) database** (see p. 30-31). The state is also promoting the use of **tele-health and remote consultations**, particularly in rural areas.	The plan repeatedly invokes "**personal responsibility**" as a way to reduce costs. It aims to increase patient engagement in care and create incentives (ex. adjusting contribution rates for insurance) for patients and doctors to seek "high-value" care. Additionally it includes provisions **directing providers to educate patients** on relevant health issues during their care experience. Arkansas will use its improved HIT infrastructure to **improve patient access to their health information**.

Health and care data used to measure progress towards goals will be collected by payers (Medicaid and commercial) as well as through the all-payer portal, and then analyzed according

to standardized metrics (p.41-42). These metrics will be determined by the Arkansas Agency for Healthcare Research and Quality and will align with Children's Health Insurance Program Reauthorization Act (CHIPRA) standards and Center for Medicaid and Medicare Services (CMS) adult quality standards (p.14).

Exhibit A: Arkansas Health System Improvement



Maine

CMMI has awarded Maine $33,068,334 to implement its health care transformation plan. Maine aims to increase transparency for consumers, re-align provider incentives to quality rather than care volume, and increase access to team-based, coordinated care. The Maine SIM plan reforms both the MaineCare Medicaid program and participating private payers.

Delivery Reform	Payment Reform
Maine is incentivizing the creation of multi-payer **Accountable Communities of Care (ACCs)** and the increased use of **PCMH**s and **Health Homes** to provide primary care. These incentives include logistic/technical support during the transition and financial incentives based upon shared savings. Behavioral Health Homes have been incentivized to provide integrated care for MaineCare patients with serious mental illness through enhanced monthly reimbursements.	Maine payers (public and participating private) will align ACO and PCMH payments within a **shared savings/risk** framework, then encourage practices to transition to a model using **global capitation with quality controls** on an ongoing basis (p.87-88). Payment models will be designed to incentivize increased efficiency and will all rely on a common set of metrics for evaluation.
Infrastructure	**Other**
Maine is creating an **all-payer provider portal** that will increase communication between different payers and providers. Additionally, it is creating a **multi-payer patient portal** that will increase cost transparency and give patients better access to their information. Wherever possible, **data systems will be standardized, streamlined and consolidated** within the state HIE infrastructure so that there is less fragmentation of health care data.	A **Community Health Worker Pilot** program will increase outreach, education, access to preventative care, and networking between providers and community health institutions. **Community Care Teams** will be implemented to connect high-risk patients with resources that reduce their risk factors (ex. nutritionists).

Health and care metrics are determined by the Maine Health Management Coalition (MHMC) and will be used to gauge progress towards program goals, inform stakeholders, guide future reforms, and provide transparency to consumers. Metrics will be publicly posted on the MHMC site and released annually in a printed fact-book.

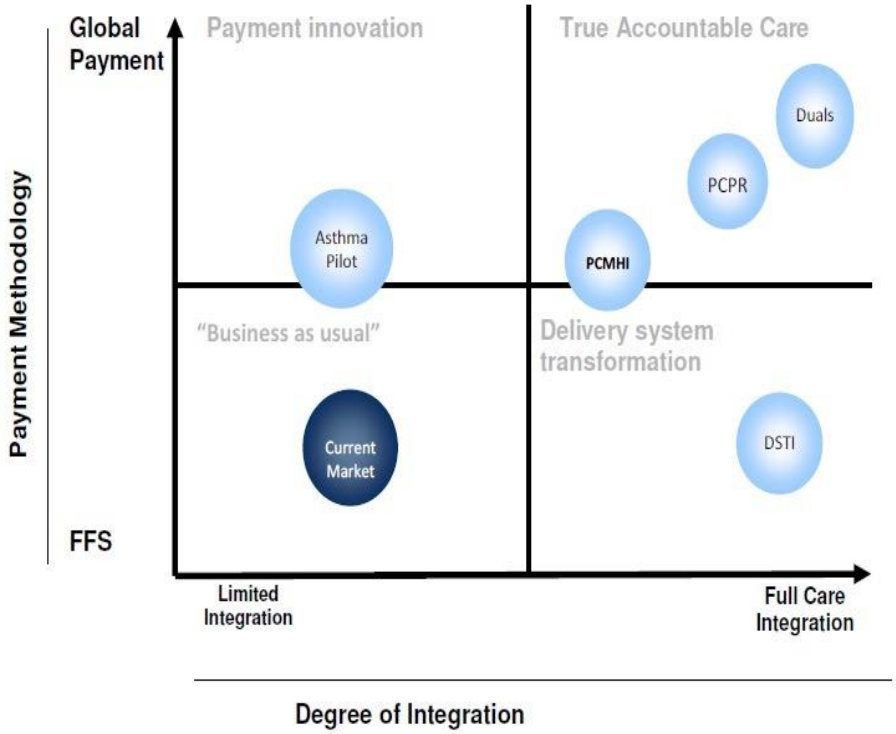
Massachusetts

CMMI has awarded Massachusetts $44,011,924 to implement its health care transformation plan. The plan includes both public and private payers, and focuses on building upon MA's strong health care infrastructure to increase access to primary care and reduce costs.

Delivery Reform	Payment Reform
Massachusetts is incentivizing primary care providers (defined in MA to include hospitals, group practices, community health organizations and mental health facilities) to become **PCMH**s. These incentives include expertise, **technical/logistic support**, and potential financial incentives. Additionally, it is promoting the creation of **multi-payer ACOs** that facilitate coordinated care.	Massachusetts aims to **standardize payment structures across payers using a shared-savings model** that calculates payments based upon the estimated cost of care. As long as care quality remains at acceptable levels, PCMHs will be incentivized to keep costs below the estimated levels, as doing so will increase their compensation; conversely, providers share liability if costs exceed estimated levels or care quality falls below the minimum.
Infrastructure	**Other**
Massachusetts is creating a **cross-payer provider hub** that will increase communication between payers, providers, and community health institutions—this hub will also facilitate the communication of best practices across providers. The state **HIE will be updated** to standardize data collection, quality metrics, and data sharing.	

Health and care metrics are determined by the Statewide Quality Advisory Committee (SQAC), using CHIPRA and adult CMS ACO metrics as a guide—see p. 45 of the project narrative for a summary of current metrics and data sources. Individual providers (ACO+PCMH) will have some latitude in determining their goals, based upon the populations that they serve. Massachusetts plans to issue its own state PCMH certification process, based on NCQA standards but adding state-specific requirements around resource stewardship, patient experience, population health management and behavioral health integration.

Figure 7. MassHealth Initiatives Support Payment Reform and Care Integration



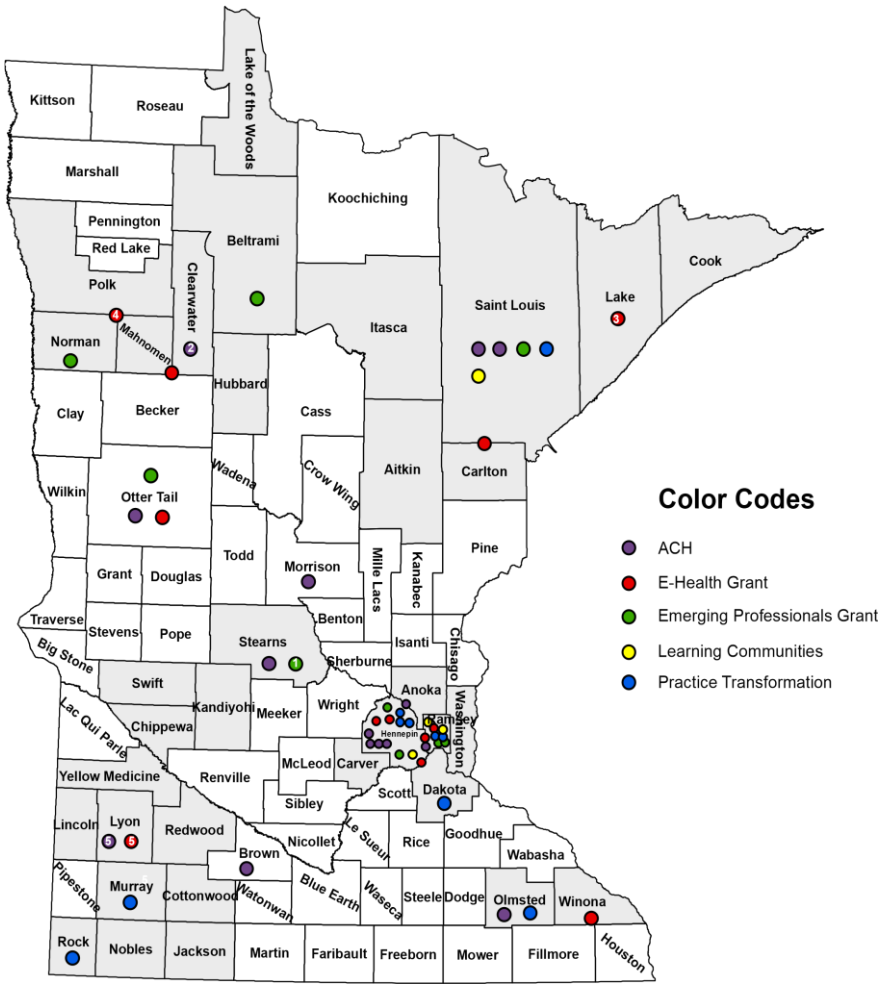
Minnesota

In 2013 the Center for Medicare and Medicaid Innovation (CMMI) awarded Minnesota a State Innovation Model (SIM) testing grant of $45.2 million to implement the Minnesota Accountable Health Model. The goal of the model is to improve health in communities, provide better care, and lower health care costs by testing new ways of delivering and paying for health care. The Minnesota Accountable Health Model is a joint effort between the Department of Health (MDH) and the Department of Human Services (DHS) with support from Governor Mark Dayton's office.

Delivery Reform	Payment Reform
Through SIM funding, Minnesota is able to expedite the implementation of **Behavioral Health Care Homes** (BHH), which provide coordinated delivery of primary care and behavioral health services. Fifteen **Accountable Communities for Health (ACH)** have been established with a goal of developing clinical and community partnerships that provide patient-centered, coordinated care. SIM funding was granted to ACHs through a competitive bid process to provide financial and technical support, and further develop infrastructure and partnerships to provide long term sustainability.	Through the Integrated Health Partnerships (IHP) demonstration Medicaid Accountable Care Organizations (ACOs) are transitioning to a **shared savings and risks payment model.** Participants share in savings and the risk for losses when attributed member's total costs for care are measured against targets for cost and quality.
Infrastructure	**Other**
Minnesota is spending a large percentage of its grant (>40%) to support e-Health exchange and the meaningful use of data. Minnesota has created a web-based **partner portal**, run by the Dept. of Human Services that will collect medical and claims information across all Integrated Health Partnership (IHPs). Analysis of the data collected improves future transformation efforts and will allow the providers to identify opportunities for improved health care outcomes. Additional funding is being granted to providers to support the secure exchange of medical or health related information between organizations participating in the Minnesota Accountable Health Model.	The Minnesota Accountable Health Model includes multiple programs within five primary drivers; each dedicated to achieving the triple aim (improved health, better care, lower costs), including but not limited to: • Driver 1: HIT/HIE - Providers have the ability to exchange clinical data for treatment, care coordination, and quality improvement. • Driver 2: Data Analytics - Providers have analytic tools to manage cost/risk and improve quality. • Driver 3: Practice Transformation - Expanded numbers of patients are served by team-based integrated/coordinated care. • Driver 4: ACH - Provider organizations partner with communities and engage consumers, to identify health and cost goals, and take on accountability for population health. • Driver 5: ACO Alignment - ACO performance measurement, competencies, and payment methodologies are standardized, and focus on complex populations.

Quality metrics were selected by DHS, using the Statewide Quality Reporting and Measurement System (SQRMS) as a guide. Minnesota elected to incorporate currently reported metrics to minimize additional provider burden.

SIM Awardees by Minnesota County



Note: Shaded counties represent areas served with SIM funded projects

KEY

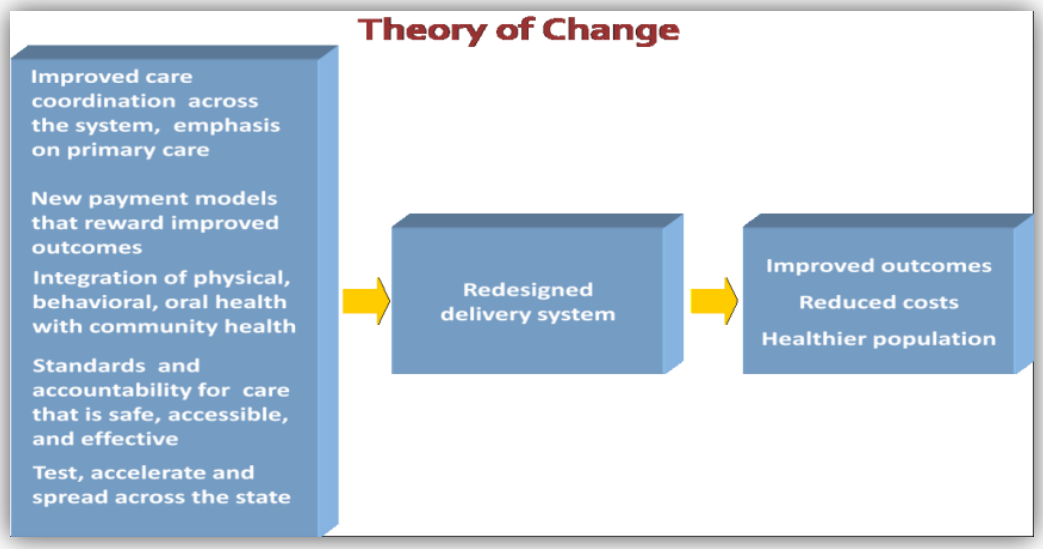
1. Hennepin and Stearns
2. Clearwater, Hubbard, Beltrami, Lake of the Woods
3. St. Louis, Lake, Itasca, Carlton, Cook, Aitkin
4. Polk, Norman, Mahnomen
5. Chippewa, Cottonwood, Jackson, Kandiyohi, Lincoln, Lyon, Murray, Nobles, Redwood, Rock, Swift, Yellow Medicine.

Oregon

CMMI has awarded Oregon $45,000,000 to implement its health care transformation plan. This plan will begin to transform the Medicaid delivery system to rely on PCPCHs for integrated care, while implementing a pay-for outcome reimbursement model.

Delivery Reform	Payment Reform
Oregon is promoting the creation of **Patient Centered Primary Care Homes (PCPCH)** that provides integrated care. **Coordinated Care Organizations (CCOs)** and PCPCHs will supply care to regions in the state and will become accountable for care quality, accessibility and efficiency. Additionally, these CCOs will be tasked with **promoting preventative care**, including behavioral, oral and physical preventative care. The shift to the CCO model has started in the Medicaid system and will be phased into the dual eligible population and state worker payer. During the shift, providers will be given **technical and logistic support** through the State Innovation Center.	PCPCHs and CCOs will transition away from a fee-for-service payment model and towards a fee-for outcome model. First, the state will promote **shared savings/risk and episodic models** but the end goal of this reform is a **globally-budgeted model** (however, this transition will take significant time.).
Infrastructure	**Other**
The **Oregon Transformation Center** will be the central hub for collecting health/care data and directing the reform process. Additionally, it will analyze Oregon health data in order to find best practices and distribute this information across providers. The findings of the Transformation Center will be implemented on an ongoing basis and will help the SIM reforms be more dynamic and reactive to the conditions on the ground. Oregon will **expand its Health Information Exchange (HIE) system** and incentivize adoption by care providers.	CCOs will convene **Community Advisory Councils** that bring together local health advocates, community groups and other stakeholders, so they can have input while determining community health needs.

Health and care metrics will be created by the Metrics and Scoring Committee, using existing metric systems and input from Oregon CCOs. Population health metrics will be guided by national CHIPRA, Substance Abuse and Mental Health Services Administration (SAMHSA), and adult CMS metrics. See Appendix E of the plan for a detailed description of the 16 current population health metrics.



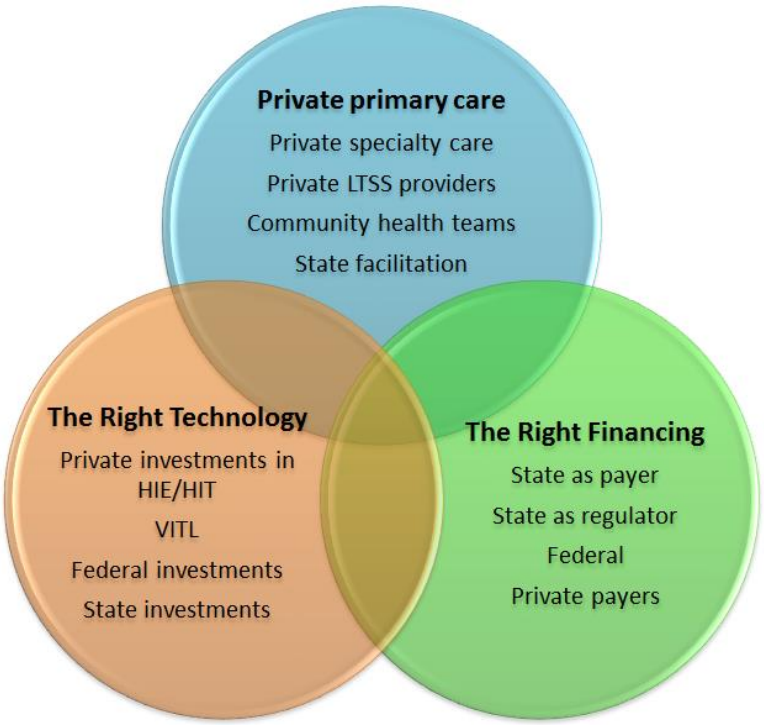
Vermont

CMMI has awarded Vermont $45,000,000 to implement its health care transformation plan. Vermont is implementing a three-pronged approach to payment reform in order to study the most efficient reforms for its state. Vermont's payment and delivery system reforms are designed to help Vermont achieve the triple aim of better care, better health and lower costs. In order to achieve this, Vermont's SIM project is working on ensuring provider readiness for increased accountability, improving Vermont's health data infrastructure to enable all to use timely information for clinical decision-making and policy-making, and designing value-based payment models for all payers.

Delivery Reform	Payment Reform
Vermont will continue to build on its **PCMH** provider model and will use them to deliver integrated primary care. Delivery reforms will vary by payment model. **Shared Savings ACO**s will be accountable for the health of a defined population and will provide integrated care with shared savings/risk. Investments will be made to support provider transformation through sub-grants and learning collaboratives.	Vermont is testing several new payment models—**shared saving ACOs, episodes of care, prospective payment systems, and pay-for performance**—across both commercial and public payers. Each payment reform will complement the others (see p. 9 of the project narrative for details) The results of these payment **reforms will be assessed by the Green Mountain Care Board**, using a set of standardized metrics, in order to determine the most effective reforms.

Infrastructure	Other
Vermont is **updating its HIT infrastructure** in order to centralize, standardize and consolidate data. First, it is expanding its statewide HIE to improve access to care data across participating providers. Second, it is leveraging its **all payer claims data base**, which collects clinical data from Vermont payers. Third, a **multi-payer claims registry** will collect standardized utilization and quality/cost data. Additionally, Vermont is developing a **warehouse to integrate clinical and claims data for analyses**.	Vermont is trying to foster collaboration between the between the public and private sectors—promoting synergy between public and private cultures, policies and behaviors. See Venn Diagram below.

The Vermont SIM plan incorporates numerous metric for analysis across several different data sets and is focused on supporting provider readiness through its delivery reforms. To see a breakdown of these metrics and data sources, see the table on p.69-70 of the plan. The metrics will be analyzed on an ongoing basis by the Green Mountain Care Board, participating payers, and analysts contracted through the State of Vermont.



Authored By,
Josh Sager, Public Policy Intern