Trinity Health

Lead the Way

Advocating for People-Centered Care

Lessons Learned in State Innovation Model (SIM) Grants

Key Findings

The State Innovation Model (SIM) initiative has supported 38 states, territories and the District of Columbia in two rounds of awards to design and test health reforms totaling nearly $1 billion. The experiences of the SIM provide valuable lessons for current and future state health system reforms committed to payment innovation, restructuring care delivery systems and building healthy communities. Critical lessons fall into three categories:

Delivery Reform: Without efforts to restructure the way care is paid for, clinical and community reforms will fall away once directed funding ends. Therefore, payment reforms must be made in advance of, or alongside of, system transformation efforts. Additional learnings include:

- Leveraging funding, infrastructure, partnerships and other structures and processes from previous or concurrent reform initiatives facilitates start-up and implementation of delivery and payment reforms.
- State-led multi-payer delivery reforms that qualify as an Alternative Payment Model (APM) take longer than three years to develop.
- The limited extent of state regulatory or legislative authority over commercially insured populations underscores the need for evidence-based models that are supported with a business case for payers and provider to incentivize participation.

Population Health: Local efforts to promote population health and address the social determinants of health are critical components of SIM efforts, and typically include locally driven and led collaboratives with clinical and non-clinical participation. However, communities have variable levels of skills and readiness to take on these efforts. Therefore, stakeholders must be prepared to provide technical assistance, sustained funding and ongoing engagement tailored to each community. Additional learnings include:

- Health systems and health plan leaders across the state must publicly embrace and sustain senior-level commitment to these initiatives.
- "State as first mover" purchasing power is often necessary to create the momentum for statewide health system transformation.

Health Information Technology: Data and metrics for health system performance have many important uses and numerous stakeholders, making it easy to take on too much in the heath information technology (IT) agenda. Each health IT initiative takes time and considerable change among all parties. Reform efforts must be deliberate and avoid overreaching capacity for change. Additional learnings include:

- Support greater alignment of quality measures across payers and an overall movement to outcome-based measures, including patient-reported outcome measures (PROMs). Focus should be on the development of nationally recognized core quality metrics, an APM reporting tool, and standardized data collection.
- States can leverage their mandate authority to require, and thus accelerate provider participation in data reporting and health IT adoption.

Introduction

The State Innovation Model (SIM) initiative offers an unprecedented opportunity to improve population health through innovations and health reform progress across the country. Throughout SIM development and implementation, Trinity Health has been a thought leader, strong partner, and firm advocate with a shared passion for change that is fundamental to implementing and sustaining long-term improvements. Trinity Health is committed to building a people-centered health system focused on delivering better health, better care and lower cost in the communities we serve. The SIM provides critical supports for this effort.

In alignment with the goals of a People-Centered Health System, Trinity Health has been an advocate and engaged partner in the nine testing grant states within the Trinity Health footprint: Connecticut, Delaware, Idaho, Iowa, Massachusetts, Michigan, New York, Ohio, and Oregon.

One State's Story

The ultimate goal of Washington state's Health Care Authority (HCA) is to achieve a healthier Washington that is consistent with the Quadruple Aim (better health, better care, lower costs and care of the provider) by containing costs while improving outcomes that include both the patient and provider experiences.

While state approaches to SIM vary, the State of Washington has been an early and bold leader. Its comprehensive approach to transforming health care includes changing the way it purchases health care.

Consistent with a 2014 law and the Healthier Washington strategy, the HCA pledged that 90 percent of its provider payments under state-financed health care programs will be linked to quality and value by 2021. This encompasses Washington Apple Health (Medicaid) and the Employees and Retirees Benefits (ERB) programs. The effort focuses on whole person care using an Accountable Communities for Health (AHC) model. HCA's goal is that Washington's annual health care cost growth will be less than the national health expenditure trend. The groundbreaking five-year Medicaid transformation project, agreed to by Centers for Medicare and Medicaid Services (CMS) in 2017, allows the state to invest in comprehensive Medicaid delivery and payment reform, and has been a critical policy lever.

As policymakers seek greater value from the national health care system, expanding upon delivery system transformations and payment models tested during SIM experimentation will prove valuable. The purpose of this white paper is to highlight efforts worthy of adoption in other states and lessons learned from SIM state experiences. The white paper also provides policy recommendations that all states can adopt with the goal of building a solid transformation infrastructure, regardless of SIM participation.

SIM Overview

States play a critical role in innovation and delivery of high-quality care given their wide reach along with their policy, regulatory and convening authority. The SIM initiative was developed to help states improve the health of their residents by transforming the delivery of care as well as invest in new approaches to support individuals and communities pursuing healthy living. SIM grants have been an important vehicle for states to develop and implement a broad plan for health system transformation.

Each state's pathway, approach and scope has been unique, but all have served as mechanisms to help states and policymakers support collaboration with payers, providers, patients and other stakeholders in designing models and solutions that respond to their needs, values and populations. While the Center for Medicare and Medicaid Services (CMS) continues to evaluate the activities and outcomes of SIM, early findings show that states can be successful conveners, offering effective leadership and support. States also offer prior experience leading complex initiatives as well as a platform for decision-making and cross-stakeholder collaboration. While states are well positioned to foster delivery system transformation, they vary in their experience, readiness for change, and available resources.

The SIM initiative was launched by CMS in 2013 to test the ability of state governments to use their policy and regulatory levers to accelerate health care transformation efforts in their states, with a primary goal to transform more than 80 percent of payments to providers into innovative payments and service delivery models. The core components of SIM include: multi-payer participation, sustainable governance (private public partnership and stakeholder engagement), health IT, movement to risk, population and community health investments, and quality measurement and accountability.

Supporting Successful System Transformation

Achieving people-centered care requires more than transforming payment and care delivery models. It also requires integrating care delivery with community health efforts to build healthier communities. Regardless of direction and scope, the support and engagement of stakeholders makes the difference between temporary fixes and lasting change. Success requires a commitment from — and alignment among — public and private payers, providers, consumers, and the federal and state governments. Health systems, hospitals, providers, consumers and many others make up the fabric of SIM initiatives and will carry on with reforms after the SIM grants conclude. Federal initiatives, like the SIM, that support the progress of states have been critical to advancing these important goals and have demonstrated the potential for coordinated, cross-sector and multi-pronged action.

Payment and Delivery Reform

Payment reforms and a drive toward value are fundamental to SIM work, and are a necessary precursor to lasting delivery system change. The coordinated participation of multiple payers in state delivery system and payment reforms enhances the potential of these efforts to strengthen the role for primary care; foster more integrated care for high-need, of high-cost beneficiaries; and drive improvement in quality and outcomes in Medicaid.

Driving Alternative Payment Models

SIM Examples Worthy of Replication:

As part of its SIM strategy, Ohio implemented three approaches to delivery and payment reform: **Comprehensive Primary Care (CPC) Model, Primary Care Medical Home (PCMH), and episodes of care (EOC) payments.** The state engaged payers, employers, health care providers and patient advocacy organizations in the design and implementation of these value-based payment models to ensure necessary buy-in. Ohio also improved its data analytics and information technology infrastructure in order to enable the implementation of these models.

Oregon's Coordinated Care Model (CCM) consists of two key structures transforming care delivery and payment models: **Coordinated Care Organizations (CCO) or Accountable Care Organizations (ACOs)** that were launched initially in 2012 through an 1115 waiver and **Patient-Centered Primary Care Homes (PCPCH).** PCMHs that were launched in 2009. The SIM funding also helped to fund the Transformation Center, which provides technical assistance to CCOs, facilitates collaboration among stakeholders, and works to enhance the state's data analytics capability and All-Payer All-Claims database.

See Appendix for more information on these case studies.

Under the SIM, states have sought to address systemic incentives that emphasize volume over value, and reactive and acute care over preventive and primary care. A key component of this is to phase risk into value-based payment strategies over time, and create more simplified financial models with an appropriate risk and reward balance. Additionally, states are implementing a range of alternative payment models — rather than fee-for-service — to change provider financial incentives, including ACOs, patient-centered medical homes (PCMHs), and episodes of care (EOC). (See Table 1 for SIM states APM model adoption).

Support for flexible and fair APMs that recognize the required support for new models and do not prematurely push providers toward risk is important. Payment methods incentivize and reward a consistent set of activities and are flexible enough to allow different levels of risk and reward. The most effective payment models contain transparent and predictable methodologies that reduce provider burden, thus increasing provider acceptance. Success includes payers engaging in new APM models at the onset of development and with an eye toward all-payer alignment.

Table 1: SIM State Alternative Payment Model (APM) Adoption

	EOC bundles (shared savings or losses)	Foundational support (per member/ per month) tied to performance or activities	Upside shared savings	Upside and downside shared savings	Prospective capitation with full risk for total cost of care	Allows payer to choose payment models
Arkansas	X	X	X			
Colorado						X
Connecticut		X	X			
Delaware						X
Iowa						X
Idaho		X				
Massachusetts			X	X	X	
Maine		X	X	X		
Michigan		X				
Minnesota			X	X		
New York		X				
Ohio	X	X	X	X		
Oregon						X
Rhode Island		X		X		X
Tennessee	X	X	X			
Vermont		X	X			
Washington		X	X	X		X

Sources: RTI International, 2017. https://downloads.cms.gov/files/cmmi/sim-rd1mt-thirdannrpt.pdf;

RTI International. 2018. https://downloads.cms.gov/files/cmmi/sim-round2test-secondannrpt.pdf
Health Information Technology (IT) and Data

Health Information Technology (IT) and Data

Health IT and data-sharing infrastructure are essential to increased care coordination and the accelerated progress toward delivery system transformation. SIM grants have enabled expanded use of technology and interoperability.

SIM states undertook a wide range of approaches to improving utilization of health IT, including all payer claims databases (APCD) or other data sharing tools, and analytic and quality reporting. Collecting data and allowing it to analyze across payers is critical to driving value-based purchasing and transparency. There should be an expectation of transparent data reporting, infrastructure development for data collection and analytics, and adoption of uniform quality metrics in all reform efforts. Furthermore, APCDs can advance population health goals, and provide the ongoing infrastructure to help address public health crises that may benefit from data sharing.

Transforming Care with Health IT

SIM Examples Worthy of Replication:

Idaho is using its SIM grant to implement the **virtual PCMH model,** which is a unique approach to the development of PCMHs in underserved and rural areas. The virtual PCMH model tested the impact of telehealth technology along with community health workers (CHWs) and community health emergency medical services (CHEMS) personnel in extending the PCMH team-based care model across rural communities. The virtual PCMH model also allowed for integration of behavioral health services in remote communities via telehealth services.

In one **Michigan Community Health Innovation Region** (CHIR), staff from 11 local health and social service organizations use technology to better coordinate care for frequent users of emergency department services. These care coordinators use a predictive model to prospectively identify individuals who frequently use the emergency department and communicate with one another across a shared IT platform. Through the shared care coordination platform, organizations develop care plans and securely share data to support participating individuals in real time.

See Appendix for more information on the Idaho case study.

Social Determinants of Health and Population Health

Improving population health is one goal of the SIM initiative. In response, states have established population health strategies, created regional population health collaboratives, and shared data to support community initiatives. A number of states have implemented initiatives to address social determinants of health through clinical and community-based efforts. Community health workers (CHWs) have been identified by many states as playing a critical role in addressing social determinants of health and delivering coordinated care. However, lack of reimbursement for CHW services remains a barrier to sustaining these positions. Varied and broad engagement of many partners is a critical success factor, with both community-level and statewide support available to ensure successful local action planning and implementation.

Addressing Social Determinants of Health

SIM Examples Worthy of Replication:

In **Michigan**, **Community Health Innovation Regions** (CHIRs) have helped to connect patients with local community services and leverage community benefit and public health efforts to address broad determinants of health that drive health outcomes. One lead entity, aka the backbone organization, has responsibility for assuring all functionality of the collaborative including organizing community stakeholders to assess community needs, identifying shared priorities and strategies, and implementing and monitoring the effectiveness of these strategies.

Delaware's Healthy Neighborhoods, one component of the state's multi-pronged SIM initiative, is enabling community-based collectives to develop and implement innovative approaches to promoting population health across four priority areas: 1) healthy lifestyles; 2) maternal and child health; 3) mental health and addiction; and 4) chronic disease prevention and management.

See Appendix for more information on these case studies.

SIM State Learnings

Aligning Concurrent Reform Initiatives is Critical

SIM grants have enabled states to attempt new strategies, learn from failures and pivot to new opportunities. Some states have experienced limitations in expertise and resources due to implementation of many different reforms concurrently. Questions of alignment are particularly challenging in states where beneficiaries, providers, health systems and payers may be eligible for—or are participating in—multiple initiatives with conflicting or incongruous timelines. Bundled payments and ACO approaches both achieve timely results and can operate together. PCMH infrastructure embedded in an ACO supports the ACO in developing registries and other population-based tools that are needed to manage care for a defined population. Additional time is needed to encourage continued innovation and alignment of new approaches. Success is dependent upon the alignment of federal, state and commercial efforts.

Key Learning: Leveraging funding, infrastructure, partnerships and other structures and processes from previous or concurrent reform initiatives facilitates start-up and implementation of delivery and payment reforms. States may need more than three years to establish a multi-payer delivery model that qualifies as an APM.

Data and the Health Information Exchange (HIE) Infrastructure to Support Interoperability Are Important Building Block

States are well suited to provide support for standardized technologies and leadership in promoting common data formats. This includes amendment of state regulations to remove legal obstacles to data sharing, and develop analytic platforms or event notification systems to assist providers. Other critical development areas include: 1) multi-payer data platform for care management; 2) clinical data repository; 3) integration of social determinants data with clinical data; 4) quality and cost performance improvement metrics; 5) population health improvement metrics; and 6) all payer databases.

Key Learning: States can leverage their mandate authority to require, and thus accelerate provider participation in data reporting and health IT adoption.

Cross-Payer Quality Metrics Creates Momentum

Standardization among concurrent public and private initiatives aimed at achieving similar goals as the SIM initiatives can help increase the mutual success of ongoing work, in particular with regards to data and quality metrics. Alignment with trends and initiatives in commercial and Medicare coverage can help increase the impact as health systems and plans need to reconcile these different coverage platforms. While achieving full consistency can be challenging – due to differences in the Medicare, Medicaid and privately insured populations – Michigan, Ohio, and Oregon have committed to

aligning their SIM with the Medicare Comprehensive Primary Care Plus (CPC+) initiative, enabling easier participation by providers and increasing the value of participating in any practice transformation initiatives.

Common measures and consistent care transformation strategies that have been developed by clinicians, epidemiologists and quality improvements specialists serve as an anchor for improving quality and cost performance. They also have created important incentives to provider engagement. Development of a core, discrete set of cross-payer metrics allows states to evaluate the impact of models on health and costs across payers and providers.

Key Learning: Support greater alignment of quality measures across payers and an overall movement to outcome-based measures, including patient-reported outcome measures (PROMs). Focus should be on the development of nationally recognized core quality metrics, an APM reporting tool, and standardized data collection.

Developing a Business Case for Commercial Payers

Payer engagement is facilitated by prior experience in similar models or the involvement of other payers, particularly Medicare and/or Medicaid. Payers are generally more interested in models with a clear business case or path and timeline to accruing evidence. States frequently focus their payment model efforts on the programs they have legislative or regulatory authority to impact, such as the Medicaid programs and state employees' coverage. This represents a meaningful share of a state's health spending, but not a majority. States need to create the authority to require commercial adoption of alternative payment models. In Rhode Island, the Health Insurance Commissioner's office was created to have broad regulatory authority over commercial insurers, including the power to require payers adopt alternative payment models. Idaho targeted outreach to learn about and encourage payers to pursue their own strategies when the state realized that commercial payers were not going to adopt the SIM per member/per month (PMPM) model to support the PCMH initiative.

Key Learning: The limited extent of state regulatory or legislative authority over commercially insured populations underscores the need for evidence-based models that are also supported by a business case for payers and providers to incentivize participation. States may need more than three years to build an evidence base to prove a clear business case.

Leadership and Infrastructure to Support Transformation Necessary for Sustainability

Critical learnings from state experiences show the need for transparent, inclusive governance structures. Learnings also identify the importance of governor and health system leadership that includes convening of key stakeholders for early buy-in. Health systems can support the executive branch by serving as successful conveners, offering effective leadership and support, and bringing forward prior experience of leading complex initiatives and support for a platform for decision-making and cross-stakeholder collaboration.

On average transformation is a five- to seven-year process and requires a number of key elements to be in place, including: 1) information systems, performance measurement and improvement; 2) VBP contracting and compliance monitoring; 3) medical and care delivery expertise and innovation; 4) finance, reimbursement and actuarial expertise; 5) workforce development and innovation; 6) clinical prevention and social determinants of health; and 7) federal and state policy and regulation. Relentless infrastructure planning and investment is necessary for payment reform and delivery system transformation at both the state and health system level.

Key Learning: All stakeholders – government, health plans, providers and patients – must embrace development of and the ongoing support for sustainable governance models that can withstand executive leadership change.

Leveraging Purchasing Power to Create Momentum at the State Level

To truly transform the delivery and cost of health care, all payers – public and private – must move toward value-based care. States can lead the alternative payment model movement by purchasing value based products for state employees and Medicaid participants. Experiences learned from this contracting effort can be shared with other states. States can use policy and contracting levers to further prevention and health-related social needs.

Key Learning: "State as first mover" purchasing power is often necessary to create the momentum for statewide health system transformation. States should share their learnings with one another. Medicaid programs can address social determinants of health.

Opportunities Ahead

As CMS funding for SIM wraps up, it will be essential to prioritize sustainability and continue the progress made under the SIM initiatives.

Recommendations for SIM States

Continued stakeholder commitment and sustained drive toward innovation and reform is essential for transformation.

- Alignment Across Payers – States should align the delivery and payment transformation progress made across payers (Medicaid, Medicare and commercial). A commitment to aligned payment methodologies and quality metrics will benefit all residents. States should continue to evolve existing models and programs that drive value based care including offering more opportunities for private payers to participate, promote population health and engage beneficiaries. Administrative simplification creates savings.
- Support Population Health – Social determinants of health can be better addressed though greater alignment and linkages between the health care system and social service programs.
- Risk-based Payment Models – States, payers and providers can build upon the progress made in adopting new models of care and upside payment models to develop and implement value-based models that eventually incorporate downside risk. The most effective way for states to engage providers is by offering programs that are simplified, predictable and rewarding from inception. States can look for shared savings initially, but should expect the majority of the financial impact to be long-term decreases in the Medicaid spending trends.
- Engage Commercial Plans and Private Payers – States have made solid progress using managed care organizations to advance delivery transformation, but most residents have private coverage. All stakeholders need to be engaged in the drive to value. States can work collaboratively with commercial plans to develop the business case for adoption of alternative payment models.
- Continue the Push for Innovation – States should continue to engage with health systems, health plans and others to incent and further innovate. For example, practice transformation techniques developed under SIM can be adapted to new efforts such as the opioid crisis. Health system partners can help sustain and re-envision a post-SIM reform agenda that promotes innovation.
- Identify and Scale Successful Models – As evaluations assessing the impact of SIM initiatives are completed, states have an opportunity to direct resources into the most successful programs and to learn from the successes of other states. States can leverage this new evidence base to support the at-scale expansion of demonstration or pilot projects.

Recommendations for Broader Transformation

SIM efforts and learnings inform reform efforts in non-SIM states.

- Maximize the State as First Mover Role – States should use their unique positions as health care payer, purchaser and innovation incubator to lower health care costs, improve the health and outcomes of patients, and increase the ability for patients to access information about their care.
- Partner for Innovation – Governors and other accountable state health care executives should leverage their policy-change capabilities to engage relevant stakeholders in the development of governance structures that advance and align public and private innovation.
- Payment Reforms – States should fund and enable strategies that support transformation. Incorporating alternative payment models into Medicaid and other plans should be a question of when, and not if. During this transition, policy change that promotes care coordination, interoperability of health data exchange, integration of behavioral and physical health, telehealth and a workforce that will deliver population health outcomes will be necessary.
- Support Population Health – States should prioritize community engagement and population health efforts. This includes support for and collaboration with public health agencies to advance community health improvement and address social determinants of health.
- Learn from Experience – All states are addressing challenging health realities—investing more money than ever before in health care while health outcomes, including life expectancy, for most demographics are declining—and are positioned to learn from others who have moved first. There are many lessons to learn from the SIM experience.

Conclusion

The SIM initiative has been a catalyst for: 1) stakeholder engagement around transformation; 2) new payment policies to support transformation; and 3) innovative approaches to community engagement and population health. Learnings from SIM states that are pioneering new care and payment models in their Medicaid and state employee health programs are extremely valuable. Across states, SIM approaches reflect unique state characteristics, resources and challenges, and help to inform ongoing state innovation efforts beyond SIM-funded initiatives.

More can and must be done to support transformation. Leadership for this should come from governors and other executive branch leaders as well as health plans and providers. Success requires an inclusive governance structure accountable for defining vision and goals, along with a regular, transparent reporting of measured progress. Findings are relevant not only for SIM states but for all states ready to embrace innovation. This commitment to embrace and invest in transformation is the path to achieving high-value care and improved health outcomes for all.

Resources

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APPENDIX A: CASE STUDIES

Michigan Community Health Innovation Regions: Population Health Model

To address social determinants of health, Michigan implemented Community Health Innovation Regions (CHIRs) as one of the three pillars of their SIM initiative. CHIRs are governed by an established "backbone" community organization which is intended to build community capacity to drive improvements in population health. CHIRs conducted community health needs assessments to identify local and regional social determinants of health, ultimately implementing action plans to address key population health priority areas and connect providers with community partners.

CHIRs developed Clinical-Community Linkages plans though which CHIRs utilized health assessments conducted by PCMHs to identify patient needs and facilitate referrals to social services in the community. By partnering with local stakeholders – schools, charities, faith-based organizations and others – and providing efficient and effective wrap-around services, CHIRs helped tackle upstream causes of poor health in the region. Overall, CHIRs received a small share of the SIM funding, between $1 million and $1.5 million per year. In addition, Medicaid plans in Michigan were required to contract with CHIRs and to participate in the Clinical-Community Linkages plans. With an eye to sustainability, Michigan assisted CHIRs with operational planning on a three-year time horizon. This helped address a challenge other states experienced in operationalizing population health objectives. To maximize impact, CHIRs were encouraged to focus on implementing existing and proven solutions and to emphasize emergency room utilizers as a target population. CHIRs reached full implementation in February 2018.

Delaware Healthy Neighborhoods: Population Health Model

The purpose of the Delaware's SIM efforts was to improve health care for Delawareans as well as promote the sustainability of the health care system. Healthy Neighborhoods, one component under the state's multi-pronged SIM initiative, was specifically designed to allow community-based collectives to develop and implement innovative approaches to promoting population health across the following four priority issues: 1) Healthy Lifestyles; 2) Maternal and Child Health; 3) Mental Health and Addiction (Behavioral Health); and 4) Chronic Disease Prevention and Management.

The Healthy Neighborhoods model, which is being transformed into Healthy Communities Delaware, offered the opportunity for targeted investments in initiatives that local communities thought to be critical for their neighborhoods. Overall, Healthy Neighborhoods achieved a number of noteworthy accomplishments that would not have been possible without significant effort and energy by all of the participating local stakeholders. A selection of these accomplishments includes:

- Established infrastructure that supports diverse collectives of stakeholders, including health, behavioral health, and social services providers, community-based organizations, community advocates, and other stakeholders with expertise in the SIM priority areas.
- Supported the development of valuable partnerships and relationships among diverse community organizations, both within and outside of the identified community initiatives.
- Strengthened communication across the state about ongoing initiatives through Statewide Consortium and Local Council collectives.
- Funded eight community driven, local initiatives designed to improve population health within selected locales.
- Supported the creation of a sustainability model as the foundation for local initiatives developed to improve community health and wellbeing moving forward.

Challenges identified during implementation included those related to vendor transition, short timeframes for initiative development and implementation, limited resources and time for activities like stakeholder engagement, and restrictive program requirements.

Ohio Reform Model: Episodes of Care and Primary Care Medical Home

As part of their SIM strategy, Ohio implemented two approaches to delivery and payment reform: Comprehensive Primary Care (CPC) Model, and episodes of care (EOC) payments. The state engaged payers, employers, health care providers and patient advocacy organizations in the design and implementation of these value-based payment models to ensure necessary buy-in. Ohio also improved its data analytics and information technology infrastructure in order to enable the implementation of these models.

Ohio implemented a PCMH initiative, called the CPC Model to improve primary care delivery. Participating primary care practices received a $4 per member per month (PMPM) payment and were eligible for shared savings based on quality and cost metrics. The state had 1 million patients, 10,000 practitioners, and 161 primary care practices engaged in this model.

The EOC payment model aimed to reduce health care cost and improve quality by providing transparency to providers on their performance related to defined medical events as well as offered financial incentives for reducing costs. Since 2015, Ohio has defined and launched 43 EOCs (or episodes), nine of which are currently tied to financial incentives and ten additional episodes were linked to payment beginning in 2019. Ohio has gradually introduced these episodes in order to gather sufficient data and ensure episodes will be clinically meaningful. The episodes were designed with input from stakeholders including providers, payers and employers. Preliminary results indicate the payment model has decreased costs and improved quality.

The state has mandated the participation of Medicaid health plans in the EOC and CPC models but has not mandated the same for commercial insurers. As of April 2017, the state has required that state employee health plans implement EOCs and offer the CPC to providers. Ohio has aligned the SIM initiative with other reform initiatives where possible, in particular the CMS Comprehensive Primary Care Plus (CPC+) model. Ohio incorporated episodes of care into their Medicaid state plan amendment in January 2017, and has indicated that the episodes of care will continue to expand in the upcoming years, even after the SIM program ends.

Oregon Coordinated Care Model: ACOs & PCMHs

Between 2012 and 2016, Oregon received a $45 million SIM grant to support its Coordinated Care Model (CCM). The CCM consists of two key structures transforming care delivery and payment models: Coordinated Care Organizations (CCO) or Accountable Care Organizations (ACOs) that were launched initially in 2012 through an 1115 waiver; and the Patient-Centered Primary Care Homes (PCPCH) that were launched in 2009. The SIM funding also helped to fund the Transformation Center, which provides technical assistance to CCOs, facilitates collaboration among stakeholders, and works to enhance the state's data analytics capability and All-Payer All-Claims database.

CCOs are responsible for the coordination of physical, behavioral and dental health care within a global budget for Medicaid beneficiaries. With the SIM grant, Oregon aimed to expand CCOs to state employees, educators and qualified health plans. Oregon was successful in integrating CCM elements into the health plans serving state employees and extended the model to approximately 130,000 beneficiaries. They also expanded the initiative to the public educators, with implementation of CCM elements for their health benefits beginning in the 2017-2018 plan year. Early analysis revealed that CCOs were initiating more transformation than other types of organizations on community engagement, but document analysis underscored that there were difficulties meeting milestones and benchmarks related to culturally diverse populations.

The state supported practices adopting the PCPCH model by providing technical assistance, coaching and peer learning. More than two-thirds of eligible primary care clinics adopted the PCPCH. As practices continued to advance their PCPCH models, the state added new PCPCH tiers to recognize this greater sophistication. Commercial payers have been slower to reimburse PCPCHs for care coordination and case management activities. A preliminary analysis of the PCPCH model

demonstrated that it has generated savings of 4.2 percent per person; with $13 in savings on services including specialty care and emergency department use for each $1 spending increase in primary care by a PCPCH.

The SIM grant in Oregon enabled the state to expand existing innovations at a greater scale than they would have otherwise. CCOs have been incorporated in the state's 1115 wavier since 2012, with the current waiver extending through 2022. The SIM work built on existing authorities and infrastructure; for example, the Transformation Center was established in the existing Oregon Health Authority. As a result, the outlook for the continued SIM health reform efforts are positive because stability of these innovations were integrated at the start of the initiative.

Idaho Case Study: Virtual Patient Centered Medical Home (PCMH)

Idaho is using their SIM grant to implement the virtual PCMH model, which is a unique approach to developing PCMH's in underserved and rural areas. The virtual PCMH model tested the impact of telehealth technology and community health workers (CHWs) and community health emergency medical services (CHEMS) personnel in extending the PCMH team-based care model in rural communities. The virtual PCMH model also allowed for integration of behavioral health services in remote communities via telehealth services.

While the first round of applications for virtual PCMH designation included fewer than expected, the number of clinics participating grew to more than 30, demonstrating that this model has promise and should continue to be monitored. While progress has been made in training CHEMS personnel, Idaho has faced challenges in integrating trained personnel in the delivery system and had a concerted focus on working with community partners to help educate State Healthcare Innovation Plan (SHIP) clinics on how to utilize trained CHEMS personnel in their specific health care delivery models.

Throughout their SIM experience, Idaho made a decision to shift from further advancement of the telehealth grant program to establishment of an Extension for Community Healthcare Outcomes (ECHO) site. Known as "Project ECHO", this practice model uses multi-point videoconferencing to conduct virtual clinics with community providers including a medical expert team consisting of a physician expert, nurse practitioner, physician assistant, pharmacist, psychiatrist and social worker.

Significantly, the advancement of health IT and data exchange and reporting were critical to the success of the SHIP model. The shift to value-based payment models, expansion of care coordination within the PCMH model, and statewide tracking and reporting of a multi-payer shared set of clinical quality measures could not be fully realized without health IT. Like many states, however, Idaho encountered challenges in creating the necessary health IT infrastructure at the pace needed to match Idaho's readiness to implement delivery and payment reform.

While building the needed health IT infrastructure caused some delays to full implementation of certain aspects of the model, Idaho continued to push forward with the development of the Idaho Health Data Exchange (IHDE) functionality to address delays in connecting PCMHs and hospitals to the IHDE, which has had downstream impacts on implementing larger delivery reforms.

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