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Findings at a Glance

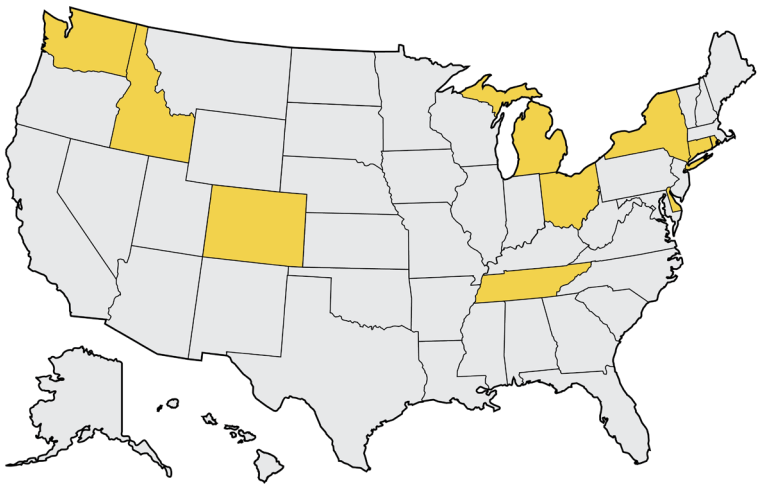
State Innovation Models Round 2 Model Test

Final Evaluation Report

BACKGROUND

The SIM Initiative tested the ability of state governments to accelerate statewide health care system transformation.

- Colorado
- Connecticut
- Delaware
- Iowa
- Idaho
- Michigan
- New York
- Ohio
- Rhode Island
- Tennessee
- Washington



- CMS awarded $20 million to $99 million per state ($660 million overall).
- Awards were made in February 2015 and ended no later than January 31, 2020.
- Awards included a one-year "pre-implementation" year and at least three years of testing.

Model Test states used SIM Initiative funds to test innovative health care models and transform their health care systems to incentivize better care and lower costs. Their approaches included:

- Primary care transformation, often through patient-centered medical home (PCMH) models (Connecticut, Delaware, Idaho, Michigan, New York, Ohio, Rhode Island, and Tennessee);
- Episode of care (EOC) models (Ohio and Tennessee);
- Behavioral health integration (BHI) in primary care practices (Colorado, Connecticut, Delaware, and Rhode Island), community mental health centers (Tennessee), and within Medicaid health plans (Washington); and
- Accountable care organization (ACO) models (Iowa, Washington).

FINDINGS

IMPLEMENTATION OF VALUE-BASED PAYMENT MODELS

- States increased provider participation in value-based payment (VBP) as payers, as purchasers, and by convening commercial payers. Delaware, Iowa, Michigan, Ohio, Rhode Island, Tennessee, and Washington increased VBP use through Medicaid managed care contracting and all experienced substantial gains in managed care enrollment. Delaware, Tennessee, Washington leveraged contracts for state employee health care coverage to increase VBP use.

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FINDINGS

IMPACTS ON SPENDING AND UTILIZATION

- In Delaware, Connecticut, Idaho, New York, and Ohio, there were decreases in total spending among patients of PCMH practices relative to comparison groups.
- Emergency department visits largely declined for patients in SIM-funded PCMHs (Delaware, Connecticut, Ohio) and BHI (Colorado, Washington) models relative to comparison groups.
- Patients at PCMH practices were more likely to have an annual primary care visit relative to their comparison groups in Connecticut, Delaware, and Rhode Island. Behavioral health visits increased for patients receiving care at practices with BHI in Tennessee and Washington relative to comparison groups.

IMPROVED CARE COORDINATION

- States increased care coordination and integration of primary and behavioral health care. Primary care and behavioral health providers used care coordination tools and screening and referral systems to help patients access care, especially when co-located services were not available (e.g., rural areas).

ADDRESSING POPULATION HEALTH

- States built infrastructure to address population health priorities at the local level. Connecticut, Delaware, Idaho, Iowa, Michigan, and Washington identified local priorities and strengthened the linkages between clinicians and social service providers. Michigan and Iowa also created systems for the identification, screening, and referral of patients with health-related social needs. These initiatives were highly valued by stakeholders.

KEY TAKEAWAYS

SIM Model Test states successfully designed and implemented payment and delivery models that yielded favorable impacts on spending and utilization. The flexibility of the SIM award allowed states to work within their existing health care landscape to complement ongoing state efforts and implement novel strategies. States increased the use of VBP models, particularly in Medicaid, and invested in primary care transformation and BHI, which increased provider capacity to provide quality care. States that addressed health-related social needs at the community and patient level also created connections between clinical and community resources. Many states sustained programs after the SIM award.

This document summarizes the evaluation report prepared by an independent contractor. To learn more about the SIM Initiative and to download the full evaluation report, visit https://innovation.cms.gov/innovation-models/state-innovations-model-testing-round-two.

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Final Evaluation Report—Colorado

MODEL OVERVIEW

Colorado's SIM goals were to improve integration of physical and behavioral health, as well as promote provider update of value-based payment (VBP). The state provided practice transformation support for primary care practices and community mental health centers (CMHCs) to integrate behavioral health and primary care services, optimize clinical data to improve quality of care, and prepare for VBP arrangements with seven payers. The Colorado SIM Initiative developed a new workforce, Regional Health Connectors, who connected clinical providers with community resources needed to improve patient health. The state also funded local public health agencies (LPHAs) and collaboratives of local health systems, mental health providers, and school districts (behavioral health transformation collaboratives [BHTCs]) to address mental health stigma reduction and prevention, in addition to screening and referral for behavioral health treatment.

FINDINGS

- **Payment Reform:** Colorado facilitated conversations between payers and providers regarding VBP requirements but did not prescribe a specific SIM payment model.
- **Delivery Transformation:** Colorado supported more than 300 primary care practices and four CMHCs in practice transformation efforts. With practice transformation coaching and clinical health information technology (health IT) support, primary care practices and CMHCs integrated behavioral and physical health and changed their care delivery.
- **Health Information Technology (Health IT):** SIM-participating primary care practices and CMHCs were unsure how to obtain and use data to show payers the value of integrating behavioral health with primary care.
- **Population Health:** Population health activities supported the development of local partnerships, collaborations, and infrastructure to successfully increase community capacity to address behavior health.
- **Sustainability:** Primary care practices and CMHCs will sustain care delivery and behavioral health integration efforts. SIM partners' investments, rather than new state or federal funding, will sustain some SIM Initiative activities.

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State Innovation Models Round 2 Model Test

Final Evaluation Report—Colorado

FINDINGS

- Colorado's practice transformation model had favorable impacts on spending and hospital service use, and unfavorable impacts on primary care provider visits in its first two years.
- Medicaid, Medicare, and commercial claims were analyzed to determine whether service use and spending changed after the SIM Initiative for individuals receiving care at SIM participating primary care practices compared with individuals receiving care from non-SIM participating primary care practices in Colorado.

1,185,151 Medicaid beneficiaries
591,811 Medicare beneficiaries
1,653,766 commercial plan members

COLORADO IBH

	Medicaid	Medicare	Commercial
Spending	☑ Total spending PBPM: Larger decrease	☐ Total spending PBPM	☑ Total spending PMPM: Smaller increase
	☑ BH-related total spending PBPM: Larger increase	☑ BH-related total spending PBPM: Larger increase	☒ BH-related total spending PMPM: Smaller increase
Utilization	☑ Inpatient admissions: Larger decrease	☐ Inpatient admissions	☑ Inpatient admissions: Larger decrease
	☐ ED visits	☑ ED visits: Smaller increase	☐ ED visits
	☐ PCP visits	☒ PCP visits: Smaller increase	☒ PCP visits: Smaller increase

☑ Favorable, statistically significant ☒ Unfavorable, statistically significant ☐ Not statistically different

Note: BH = behavioral health; ED = emergency department; IBH = integrated behavioral health; PBPM = per beneficiary per month; PCP = primary care provider; PMPM = per member per month.

KEY TAKEAWAYS

Colorado's SIM-participating providers reported that coaching and clinical health IT assistance helped them implement integrated behavioral health, which resulted in favorable changes in health care use and spending. However, challenges remained, including workforce shortages, difficulties integrating behavioral health providers into primary care, and sharing data across providers. To advance payment reform, Colorado's SIM Initiative succeeded in convening public and private payers around VBP; however, this approach did not provide a clear path to reimbursement for their integrated behavior health efforts. Colorado relied on an extensive number of partners to implement SIM Initiative activities who helped sustain some activities after the SIM Initiative concluded.

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Final Evaluation Report—Connecticut

MODEL OVERVIEW

The primary goals of the Connecticut SIM Initiative were to establish a whole person–centered health care system that improved community health and eliminated health inequities; ensured superior access, quality, and care experience; empowered individuals to actively participate in their health and health care; and improved affordability by reducing health care costs. The state aimed to achieve these goals through three key strategies: Person-Centered Medical Home Plus (PCMH+), the Advanced Medical Home (AMH) program, and the Community and Clinical Integration Program (CCIP). The state launched PCMH+, the state's first Medicaid Shared Savings Program (SSP). The AMH program was designed to provide technical assistance (TA) to help practices transform, but the state discontinued the AMH initiative early because of lower than anticipated participation. The state reallocated the remaining funds to the CCIP, which offered targeted TA to PCMH+ practices to enhance their care capabilities.

FINDINGS

- **Payment Reform:** Connecticut's PCMH+ grew to cover approximately 20 percent of all Medicaid beneficiaries in the state, with many practices reporting improvements in quality metrics and shared savings.
- **Delivery Transformation:** CCIP funded TA for comprehensive care management, health equity activities, and behavioral health integration (BHI). A community health worker (CHW) certification program was initiated to improve patient outcomes and address social needs.
- **Health Information Technology (Health IT):** A statewide health information exchange (HIE), all-payer claims database (APCD), and admission, discharge, and transfer (ADT) were established.
- **Population Health:** CHWs played an integral role in care teams and extended the reach of practices into local communities. The Prevention Service Initiative (PSI) provided TA to formalize relationships between community-based organizations (CBOs) and health care organizations.
- **Sustainability:** State funds will sustain a third cohort of PCMH+, and a fourth cohort was expected to add dually eligible Medicare/Medicaid beneficiaries. Executive orders in January 2020 shifted statewide priorities for health care spending to primary care.

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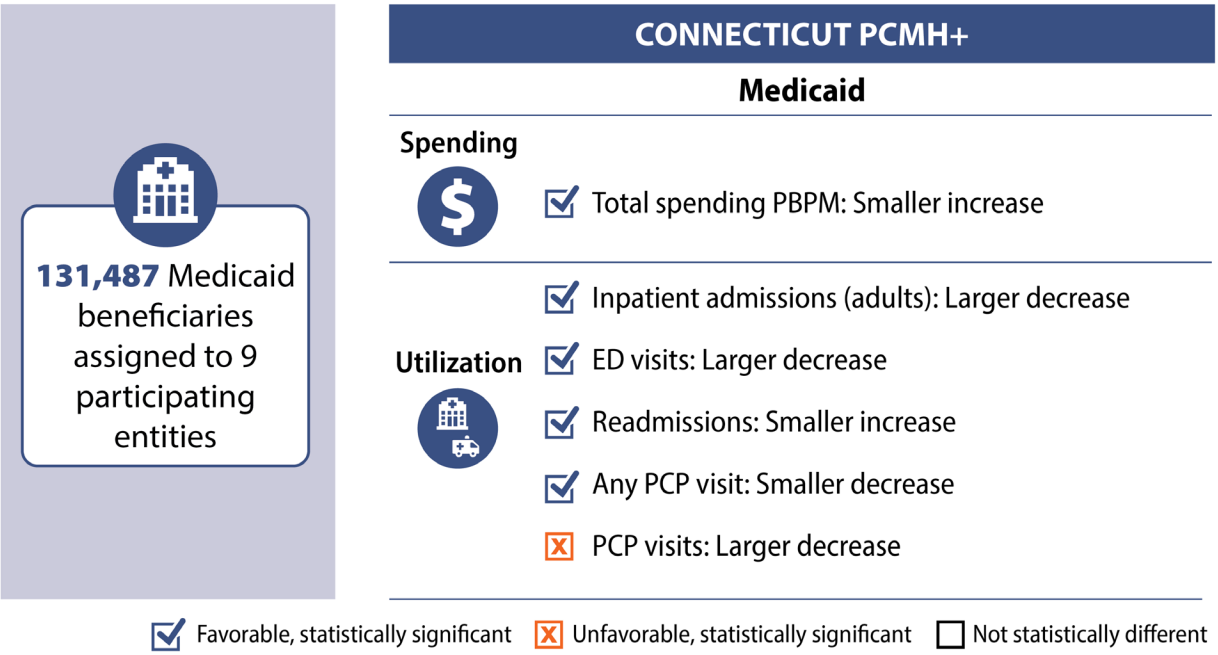
Final Evaluation Report—Connecticut

FINDINGS

- Connecticut's PCMH+ model had favorable impacts on spending, emergency department (ED) visits, and readmissions in its first 2 years.
- Medicaid claims were analyzed to determine if service use and spending changed after the SIM Initiative for individuals receiving care at PCMH+ practices compared to individuals receiving care from PCMH practices not participating in PCMH+ in Connecticut.



Note: ED = emergency department; PBPM = per beneficiary per month; PCMH+ = Person-Centered Medical Home Plus; PCP = primary care provider.

KEY TAKEAWAYS

Connecticut's PCMH+ was considered a success by providers, policy makers, and consumer advocates, reaching 20 percent of the Medicaid population and resulting in positive impacts relative to comparison practices. Practice transformation and TA efforts, including the integration of CHWs, were most advantageous when tailored to a practice's specific needs and populations. Population health activities were delayed, in part, because CBOs needed help to administer new health programs. Although Connecticut began numerous programs, the state limited its focus over time and sustained targeted programs, including PCMH+, after the award period.

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State Innovation Models Round 2 Model Test

Final Evaluation Report—Delaware

MODEL OVERVIEW

The central focus of the Delaware SIM Initiative was to assure that primary care providers received payments across payers to facilitate delivery changes and prepare providers for value-based payment (VBP) participation—while improving provider satisfaction and assuring primary care availability statewide. Core SIM Initiative programs used contractors to deliver technical assistance (TA) and training and to distribute mini-grants to primary care and behavioral health practices. Delaware's SIM Initiative also funded pilot projects developed by county-based local councils and their partners through the Healthy Neighborhoods initiative to address non-clinical, social determinants of health (SDOH), and barriers to care, and to promote healthy living. In addition, Delaware included two initiatives (i.e., the Health Care Claims Database and the Common Scorecard) to provide new data and enhance analytic tools to help payers control health care cost growth and providers to succeed under VBP arrangements.

FINDINGS

- **Payment Reform:** Because Delaware's initial voluntary, multi-payer framework resulted in little progress, Medicaid required Medicaid managed care plans to meet annual VBP targets in 2018.
- **Delivery Transformation:** The SIM Initiative award funded TA to primary care practices. The Behavioral Health Integration (BHI) Pilot Program increased screening, communication, and referrals across primary care, behavioral health, and substance use disorder providers, but the lack of payment impeded sustained change.
- **Health Information Technology (Health IT):** The Health Care Claims Database (HCCD) established a foundation for tracking the cost and quality of care.
- **Population Health:** The Healthy Neighborhoods program implemented three local councils and piloted eight community programs that were judged as successful, but lacked funding needed for major impact.
- **Sustainability:** To hold all payers accountable for high health care costs, the legislature established the Cost and Quality Benchmark process and set spending growth targets. A new consortium related to population health, Healthy Communities Delaware, established a backbone organization and coalition to identify, fund, and evaluate strategies.

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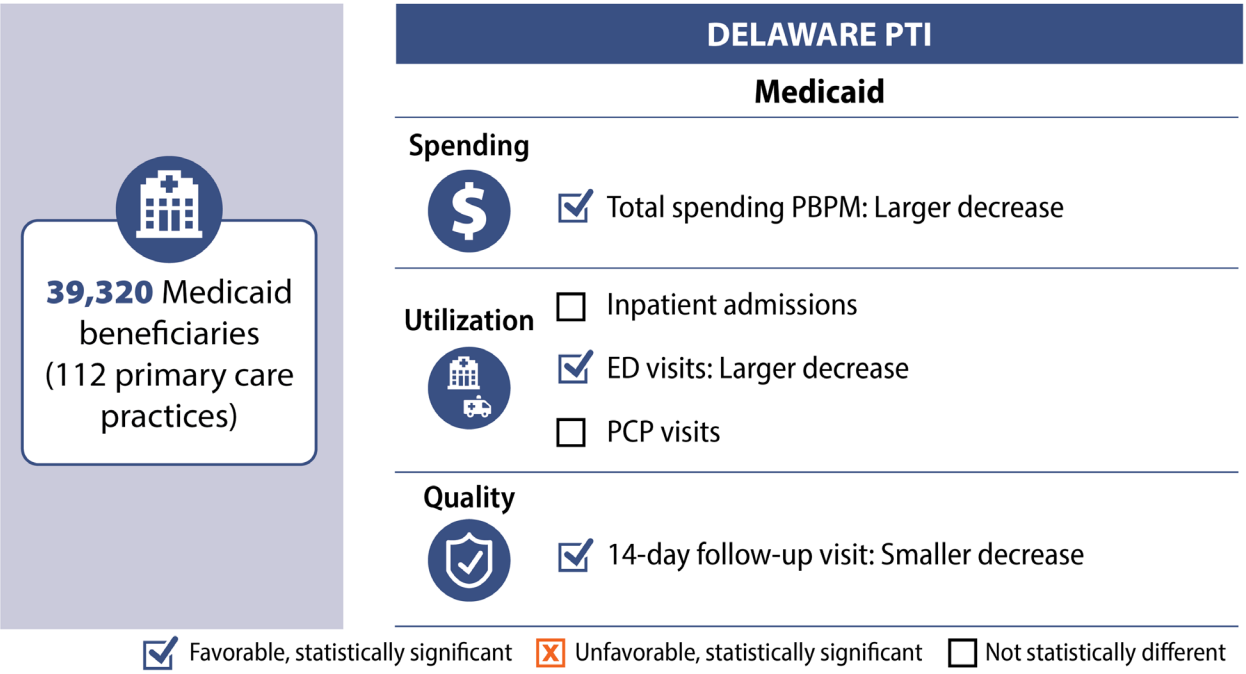
State Innovation Models Round 2 Model Test

Final Evaluation Report—Delaware

FINDINGS

- Delaware's Practice Transformation Initiative had favorable impacts on spending, emergency department (ED) visits, follow-up visits, and inpatient admissions in its first 3 years.
- Medicaid claims were analyzed to determine if service use and spending changed after the SIM Initiative for individuals receiving care at PTI participating practices compared to individuals receiving care from non-PTI practices in Delaware.



Note: ED = emergency department; PBPM = per beneficiary per month; PCP = primary care provider; PTI = Practice Transformation Initiative.

KEY TAKEAWAYS

Delaware used a significant portion of the award on TA to primary care practices, which resulted in more positive outcomes relative to comparison practices. Stakeholder engagement funded by the SIM Initiative facilitated a collaborative approach to transitioning to VBP that increased commitment from payers and uncovered provider challenges. Delaware's initial voluntary framework encouraged dialogue across health care sectors, but stronger policy levers were needed to align payers and increase payment reform. At the end of the SIM award, Delaware set spending growth targets and created a process and consortium to sustain the state's efforts.

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Final Evaluation Report—Idaho

MODEL OVERVIEW

Idaho's SIM Initiative concentrated mainly on practice transformation and health data infrastructure. Practice transformation activities included the following: (1) technical assistance (TA) and training for primary care practices to help them to achieve recognition as patient-centered medical homes (PCMHs) or to further enhance capabilities of established PCMH practices; (2) support for training and use of community health workers (CHWs) and community health emergency medical services (CHEMS); and (3) efforts to share best practices and expand care coordination. Investments in health data infrastructure included support for bi-directional connections between participating clinics and the state's health information exchange (HIE). Idaho's SIM Initiative did not implement a value-based payment (VBP) model, although the Idaho Healthcare Coalition (IHC) convened stakeholders to discuss the alignment of payment mechanisms and methods across payers and to promote VBPs, particularly in its Multi-Payer Workgroup.

FINDINGS

- **Delivery Transformation:** Idaho succeeded in engaging 165 clinics in SIM-funded practice transformation to develop or enhance their PCMH capabilities. The state also recognized 48 clinics as virtual PCMHs, established 13 CHEMS, and trained 107 CHWs.
- **Health Information Technology (Health IT):** The SIM Initiative enabled 151 out of the 165 clinics that received practice transformation support to share data via the Idaho Health Data Exchange (IHDE); providers reported using that data to improve care.
- **Population Health:** Regional collaboratives (RCs) planned and conducted projects that addressed regional population health priorities and supported all PCMHs in their region to develop new capacities and establish connections with other members of the medical-health neighborhood.
- **Sustainability:** The Healthcare Transformation Council of Idaho (HTCI) was formed to build on the transformation efforts that begun under the SIM Initiative. The HTCI planned to continue promoting person-centered health care delivery, but no future PCMH cohorts were planned.

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State Innovation Models Round 2 Model Test

Final Evaluation Report—Idaho

FINDINGS

- Idaho's practice transformation support program had favorable impacts on spending in its first 2 years.
- Medicaid claims were analyzed to determine if service use and spending changed after the SIM Initiative for individuals receiving care at practices participating in the practice transformation support program compared to individuals receiving care from non-SIM practices in Idaho.

115,320 Medicaid beneficiaries (110 practices)

IDAHO PRACTICE TRANSFORMATION SUPPORT

	Medicaid	Medicaid – Adults
Spending	☑ Total spending PBPM: Smaller increase	☑ Total spending PBPM: Larger decrease
Utilization	☐ Inpatient admissions	☑ Inpatient admissions: Larger decrease
	☐ ED visits	☑ ED visits: Larger decrease

☑ Favorable, statistically significant ☒ Unfavorable, statistically significant ☐ Not statistically different

Note: ED = emergency department; PBPM = per beneficiary per month.

KEY TAKEAWAYS

Idaho focused SIM Initiative funds on practice transformation efforts, including TA, coaching, and IDHE connectivity. PCMHs receiving these supports showed positive impacts on outcomes for adult beneficiaries. Clinics located throughout Idaho, which serve almost half of the state's population, became PCMHs or increased their PCMH capabilities—and readied themselves to manage financial risk under VBP. Although challenges with health IT persisted throughout the SIM Initiative, most participating practices were connected to the IHDE by the end of the award period and primary care providers were using that data to improve patient care. After the award period, Idaho did not intend to recruit more primary care practices to participate in PCMH transformation and will instead focus primarily on VBP expansion.

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MODEL OVERVIEW

Iowa's SIM Initiative intended to achieve statewide health care transformation through two primary drivers: (1) value-based payment reform, focused on aligning payers and providers in value-based purchasing; and (2) delivery system reform, directed at equipping providers with tools to engage in population health with a focus on outcomes. The state established county-based Community and Clinical Care initiatives (C3s), using the Accountable Communities for Health (ACH) model. SIM-funded activities also included developing a Medicaid value-based purchasing program, deploying a statewide admissions, discharge, and transfer (ADT) alerting system, and providing technical assistance (TA) to health care and community service providers. During the SIM Initiative, the state shifted toward managed care systems with multiple new managed care organizations (MCOs) serving most Medicaid beneficiaries.

FINDINGS

- **Payment Reform:** Iowa's value-based purchasing program initiative focused on Medicaid, promoting value-based purchasing arrangements between MCOs and accountable care organizations serving the Medicaid population.
- **Delivery Transformation:** The state changed from using common performance metrics to customized performance measures that matched providers' priorities.
- **Health Information Technology (Health IT):** The SIM-funded Statewide Alert and Notification (SWAN) ADT alert system, despite its reported deficiencies, was judged a success in persuading providers of the importance of sharing data to achieve effective care transformation.
- **Population Health:** In addition to the seven original C3s, Iowa added 11 new ACH expansion sites. Stakeholders praised the C3s for bringing social determinants of health (SDoH) to the forefront and achieving cooperation in their counties' health care environments.
- **Sustainability:** The Governor's Healthcare Innovation and Visioning Roundtable committed to convening and leading future efforts in health care delivery transformation in the state.

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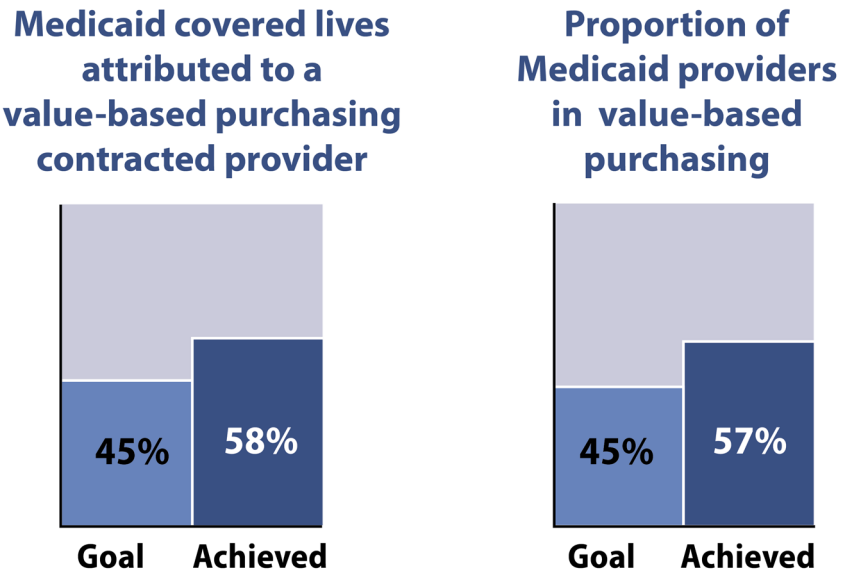
Final Evaluation Report—Iowa

FINDINGS

- Iowa's SIM Initiative surpassed its 45 percent goal of Medicaid covered lives in a SIM-aligned value-based purchasing contracts, though such contracts typically were not risk-based or sophisticated enough to meet Advanced APM criteria.
- The proportion of Medicaid providers participating in SIM-aligned value-based purchasing arrangements was almost 57 percent, and the proportion of covered lives in those arrangements was between 54 and 58 percent.



KEY TAKEAWAYS

The SIM Initiative supported a "culture change" around value-based purchasing. Embedding value-based purchasing requirements in Medicaid contracts was an effective lever for promoting payment reform, though challenging with MCO turnover. Iowa's delivery system reform activities became more provider-driven over the award period, which allowed for transparency and flexibility. State officials considered the C3 initiative to be one of the biggest successes of Iowa's SIM Initiative, as it demonstrated the value of cross-sector collaboration and the important role of SDoH. Iowa planned to sustain most components of the SIM Initiative, including several of the C3s, which were intended to be self-sustained through leveraging existing funding streams.

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MODEL OVERVIEW

The Michigan SIM Initiative, through enhancements to primary care practices across the state and the development of five sub-state Community Health Innovation Regions (CHIRs), aimed to improve population health by strengthening the relationships between clinical care providers and community-based organizations (CBOs) that address social determinants of health (SDoH). The state used SIM funding to support three strategies: (1) improving population health and reducing unnecessary medical costs through community-wide systems change in the five CHIRs; (2) transforming the care delivery system by supporting patient-centered medical home (PCMH) principles and incentivizing adoption of VBP arrangements; and (3) engaging practices and payers in Michigan Health Information Network (MiHIN), the state's health information exchange (HIE), to support care management and coordination.

FINDINGS

- **Payment Reform:** Building on a prior project, primary care practices in Michigan's SIM PCMH Initiative received per member per month payments to support practice transformation and care management.
- **Delivery Transformation:** PCMHs and CBOs deployed an SDoH screening tool, and PCMHs addressed referrals in house or referred them out to CBOs. The Practice Transformation Collaborative trained care coordinators, care managers, and community health workers (CHWs).
- **Health Information Technology (Health IT):** The MiHIN integrated the operations of several regional HIEs to track active patient–provider relationships and facilitate data collection, data reporting, and admission, discharge, and transfer (ADT) notifications.
- **Population Health:** The five CHIRs improved community clinical linkages and provided a mechanism to meet patients' needs through referrals to social services organizations. Other efforts identified individuals who were frequently using the emergency department and experiencing homelessness.
- **Sustainability:** Medicaid Health Plans had contractual incentives to continue payments to PCMHs and move toward alternative payment models (APMs). Additional state funds sustained core staffing and CHIR infrastructure, as CHIRs pursued funding from other sources.

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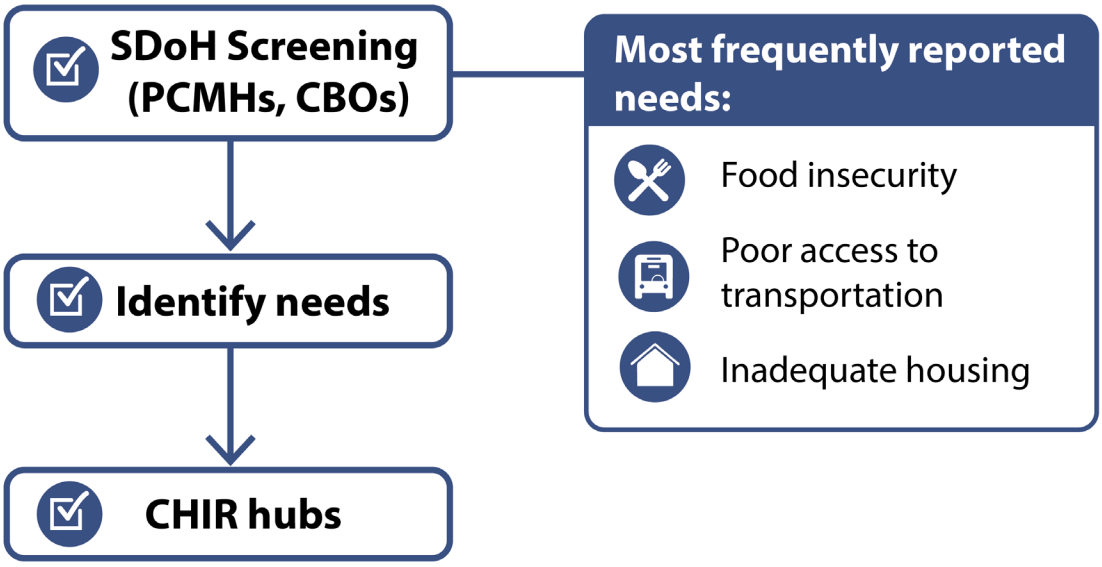
Final Evaluation Report—Michigan

FINDINGS

- By spring 2019, patients at SIM-participating PCMHs and clients of CBOs were screened for social needs at least once per year, regardless of insurance type, and were referred for support services through CHIR hubs when needed.
- Medicaid claims analyses on the impact of the MI CHIRs showed inpatient admissions decreased for both Medicaid beneficiaries in CHIR counties and comparison beneficiaries but decreased less in CHIR counties.



Note: CBO = community-based organization; CHIR = Community Health Innovation Region; PCMH = patient-centered medical home; SDoH = social determinants of health.

KEY TAKEAWAYS

Michigan's SIM Initiative enhanced the capacity of primary care practices to screen for SDoH and coordinate care. Michigan's CHIRs brought together diverse health and social service organizations and providers with the common mission of coordinating activities aimed at identifying and addressing patients' needs. CHIRs encountered a range of challenges but made progress overall at screening for patients' needs and referring patients to community organizations for services. However, the SIM Initiative's timeframe may be insufficient to observe potential effects on population health or service utilization. Michigan is sustaining its PCMH initiative and CHIR activities, and MiHIN will continue to operate.

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MODEL OVERVIEW

The primary goal of the New York SIM Initiative was to encourage small primary care practices to adopt the patient-centered medical home (PCMH) model of care. Because of difficulties engaging stakeholders in New York's state-developed PCMH model, the state transitioned to the New York State Patient-Centered Medical Home (NYS PCMH), a customized model based on the National Committee for Quality Assurance (NCQA) PCMH model. The state established Regional Oversight Management Committees (ROMCs) in four regions of the state that convened payers that developed and implemented local multi-payer payment approaches to incentivize primary care practices to adopt the NYS PCMH model. Simultaneously, New York launched the Practice Transformation Agent (PTA) program that: (1) recruited small primary care practices to adopt the NYS PCMH and (2) provided TA to help participating practices achieve PCMH certification. New York also developed a multi-payer quality measure report, the Scorecard, designed to help practices adopting NYS PCMH assess their performance and implement quality improvements.

FINDINGS

- **Payment Reform:** ROMCs were successful in generating multi-payer agreements, but few of the practices targeted by the ROMCs to receive payment incentives achieved PCMH certification.
- **Delivery Transformation:** Practice enrollment in PCMH transformation accelerated following transition to NYS PCMH, with 2,879 practices enrolled by the end of the SIM Initiative. Providers reported that PTAs were instrumental in helping them obtain NYS PCMH certification, but some primary care practices did not enroll because of limited practice capacity and resources. Rural residency programs and a distance learning program sought to enhance primary care in under-resourced areas.
- **Health Information Technology (Health IT):** Health IT initiatives to support practice transformation and value-based payment models advanced moderately.
- **Population Health:** Six population health (Project LIFT [Linking Interventions for Total Population Health]) efforts began in December 2018, with some intended to be self-sustaining.
- **Sustainability:** New York planned to sustain the NYS PCMH, but without the PTAs. The workforce development initiatives were expected to continue as self-sustaining programs. Stakeholders hoped payers would fund ROMCs.

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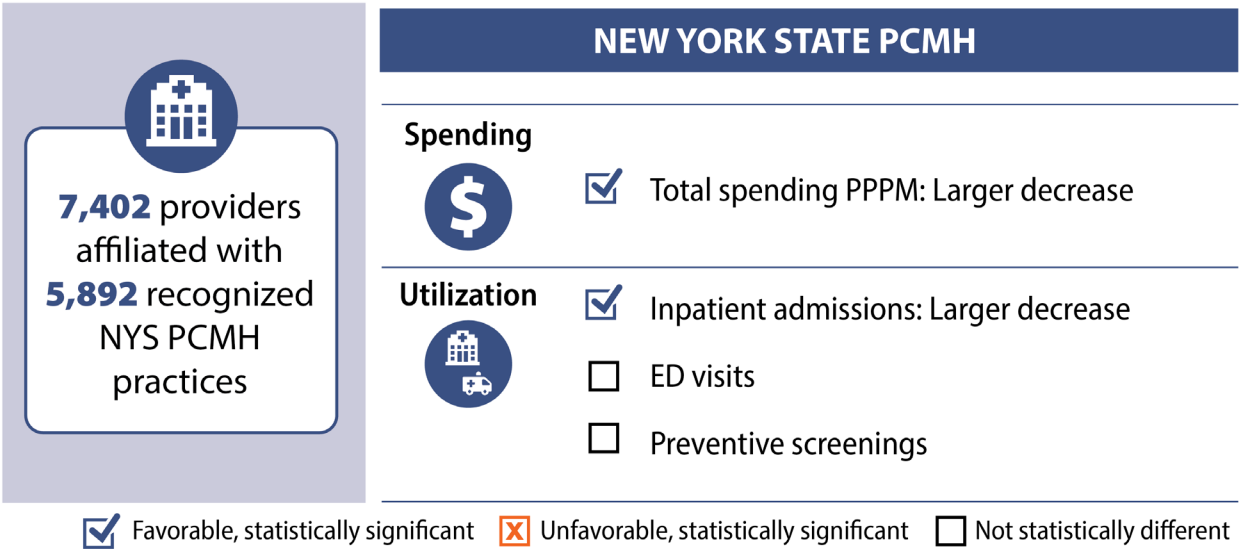
State Innovation Models Round 2 Model Test

Final Evaluation Report—New York

FINDINGS

- New York State's PCMH had favorable impacts on spending and inpatient admissions in the first year.
- Provider-level data derived from commercial claims were analyzed to determine if service use and spending changed for individuals receiving care at NYS PCMH providers compared to individuals receiving care from non-NYS PCMH providers.



Note: ED = emergency department; NYS = New York State; PCMH = Patient Centered Medical Home; PCP = primary care provider; PPPM = per person per month.

KEY TAKEAWAYS

Compared to patients in other practices, commercially insured patients in practices that adopted the NYS PCMH model sought less inpatient care and had lower spending. Rather than designing a new delivery model, as New York initially did, tweaking an established model may hasten health care transformation by stimulating more positive payer and provider interest and engagement in the transformation effort. The ROMC regional approach shows promise in improving payer engagement and cooperation. Stakeholders hoped payers would fund ROMCs after the SIM Initiative ended, but that was uncertain. Primary care practices that have not already transformed need support, and performance measurement targeted to small primary care providers may be essential to sustain transformation. The NYS PCMH model, but not PTAs, which were a significant SIM investment, will be sustained after the SIM award.

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Final Evaluation Report—Ohio

MODEL OVERVIEW

The Ohio SIM Initiative's goals were to enroll 80 to 90 percent of residents in a value-based payment (VBP) model and cover 50 percent of the state's medical spending within five years. Ohio aimed to achieve these goals through two key strategies: a patient-centered medical home (PCMH) model (known as the Ohio Comprehensive Primary Care [Ohio CPC]) and an episode of care (EOC) model. In the PCMH model, participating practices received per member per month (PMPM) payments, and for those meeting the eligibility criteria, shared savings tied to quality and cost goals for their attributed Medicaid populations. Ohio's EOC model sought to encourage high-quality, patient-centered, and cost-effective care by holding a single clinician or entity accountable for care across all services related to a given episode. In Ohio's EOC model, the entity responsible for all services related to a given episode was called a principal accountable provider (PAP). Ohio Medicaid required its managed care plans to implement the Ohio CPC and EOC models. Commercial insurers agreed to align with these strategies in principle, if not in design.

FINDINGS

- **Payment Reform:** Forty-three EOCs were launched in Medicaid. By 2017, nearly 1.6 million Ohio Medicaid beneficiaries were in an episode. In 2019, Ohio CPC included 250 practices, covering nearly half of the Medicaid beneficiary population.
- **Delivery Transformation:** The potential for practice change was limited because most PAPs were not accessing online performance reports on EOC cost and quality measures.
- **Health Information Technology (Health IT):** In 2017, referral reports were introduced to facilitate Ohio CPC referrals to higher quality, lower cost specialists. They also aligned Ohio CPC measures with the federal CPC+ program.
- **Population Health:** A school-based health care initiative was launched to improve patient engagement among Medicaid child beneficiaries and foster collaboration among health care entities and school districts.
- **Sustainability:** Funding for Ohio CPC was incorporated in the state's 2020–2021 budget and EOC and Ohio CPC requirements were included in the Medicaid managed care procurement for plans effective January 2022.

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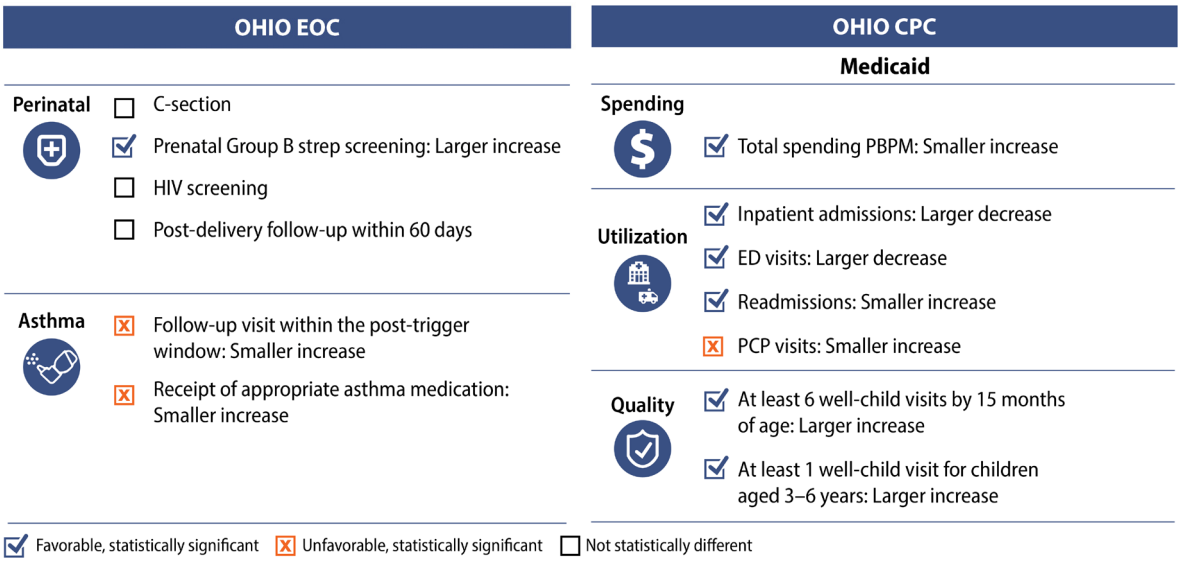
Findings at a Glance

State Innovation Models Round 2 Model Test

Final Evaluation Report—Ohio

FINDINGS

- Ohio's EOC model had no changes on C-sections, perinatal screening, and follow-up visits, and unfavorable impacts on asthma episodes in its first four years. Medicaid claims were analyzed to compare perinatal and acute asthma exacerbation episodes among individuals in in Ohio to episodes among individuals in Kansas and Kentucky.
- Ohio's CPC model had favorable impacts on spending, hospital use, and well-child visits, and an unfavorable impact on primary care provider visits in its first two years. Medicaid claims were analyzed to compare individuals attributed to Ohio CPC practices to individuals receiving care at non-Ohio CPC practices.



Note: CPC = Comprehensive Primary Care; C-section = cesarean section; ED = emergency department; EOC = Episode of Care; HIV = human immunodeficiency virus; PBPM = per beneficiary per month; PCP = primary care provider.

KEY TAKEAWAYS

Requiring Medicaid managed care plan participation in Ohio CPC and the EOC via contractual requirements and regulation: (1) increased VBP in Ohio Medicaid and (2) helped standardize implementation of Ohio CPC and EOC models across Medicaid plans. Ohio's CPC model invested in practice support activities, including patient-centered care staffing and infrastructure, and resulted in favorable impacts. In the EOC model, low PAP engagement with was a persistent challenge and impacts were generally unfavorable. Ohio designed Ohio CPC and the EOC models to be sustained after the SIM award's end as required elements of Medicaid managed care plans.

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Findings at a Glance

State Innovation Models Round 2 Model Test

Final Evaluation Report—Rhode Island

MODEL OVERVIEW

The Rhode Island SIM Initiative built on the state's existing foundation for delivery system reform by investing in a wide range of investments designed to improve access to value-based, integrated care. By fostering a "culture of collaboration" across multiple state agencies and stakeholder groups, SIM leadership bolstered the state's vision for transformation by expanding the state's Patient-Centered Medical Home-Kids (PCMH-Kids) initiative, furthering the integration of behavioral health and primary care and implementing new health information technology (health IT) tools to aid in quality reporting and care delivery. The state also invested in training the health care workforce to address the clinical and social needs of individuals with complex conditions. The SIM Initiative funded almost 15 different projects in practice transformation, workforce, health IT, and patient engagement. Almost all SIM-supported investments were sustained after the end of the SIM Initiative.

FINDINGS

- **Payment Reform:** Rhode Island expanded PCMHs to kids and aligned commercial payers' and Medicaid's transformation goals. Integrated behavioral health (IBH) improved primary care provider (PCP) capacity to treat behavioral health conditions.
- **Delivery Transformation:** Community Health Teams (CHTs) worked with PCPs to assess needs and connect high-risk patients with services. Providers received training about new payment models, behavioral health conditions, and patients' care planning.
- **Health IT:** The care management dashboards, integrated services data ecosystem, and all-payer claims database (APCD) helped improve quality reporting and care delivery.
- **Population Health:** An assessment, referral, and treatment project produced and disseminated information about smoking cessation services. SIM investments fostered connections among CHTs, Health Equity Zones (HEZs), and accountable entities to improve population health.
- **Sustainability:** Almost all SIM Initiative investments will be sustained through private and public resources. A new state government Planning and Research Unit will implement activities and support collaboration.

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Findings at a Glance

State Innovation Models Round 2 Model Test

Final Evaluation Report—Rhode Island

FINDINGS

- Among commercially insured children, Rhode Island's PCMH-Kids had unfavorable impacts on spending and favorable impacts on PCP visits in its first 3 years.
- Among Medicaid-covered children, Rhode Island's PCMH-Kids had unfavorable impacts on spending and ED visits and favorable impacts on PCP visits and well-child visits in its first 3 years.
- Medicaid and commercial claims were analyzed to determine if service use, spending and quality changed after the SIM Initiative for children receiving care at PCMH-Kids practices compared to children receiving care from non-PCMH-Kids practices in Rhode Island.

106,930 Medicaid beneficiaries
106,340 commercial plan members
(9 primary care practices)

RHODE ISLAND PCMH-KIDS	Commercial	Medicaid
Spending	☒ Total spending PMPM: Smaller decrease	☐ Total spending PMPM
Utilization	☐ ED visits ☑ PCP visits: Larger increase	☒ ED visits: Larger increase ☑ PCP visits: Larger increase
Quality	☐ Adolescents with well care visits	☑ Adolescents with well care visits: Larger increase

☑ Favorable, statistically significant ☒ Unfavorable, statistically significant ☐ Not statistically different

Note: ED = emergency department; PCMH = Patient-Centered Medical Home-Kids; PCP = primary care provider; PMPM = per member per month.

KEY TAKEAWAYS

The state successfully implemented its initiatives by creating a solid business case and engaging stakeholders early in the design process. Rhode Island's multiple investments in health IT also enhanced communication and care coordination among providers. Stakeholders viewed SIM-supported training programs, including CHTs, as particularly strong provider supports. PCMH-Kids covered a substantial portion of the state's pediatric population and increased PCP visits, although it did not consistently result in favorable impacts on cost or quality during the evaluation period. At the end of the award period, Rhode Island invested heavily in sustainability by forming a sustainability workgroup and devoting time to discussing financing options.

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Findings at a Glance

State Innovation Models Round 2 Model Test

Final Evaluation Report—Tennessee

MODEL OVERVIEW

Tennessee's SIM Initiative included three statewide strategies that primarily affected the Medicaid (TennCare) population: (1) primary care transformation, (2) long-term services and supports (LTSS) reforms, and (3) an episode of care (EOC) model. Primary care transformation comprised patient-centered medical homes (PCMHs), behavioral health homes known as Tennessee Health Link, and a care coordination tool (CCT) for providers to identify and track gaps in care. LTSS reforms focused on quality improvement and shifting to value-based payment (VBP) in nursing facilities and encompassed a range of interventions (either facility-based or in the home or community), for individuals with significant physical, cognitive, and/or behavioral needs. The EOC model encompassed care delivered by multiple providers in relation to specific, pre-determined acute health care events, with episodes overseen by key providers accountable for overall cost and quality of care.

FINDINGS

- **Payment Reform:** More than one-third of the TennCare Medicaid population was attributed to a PCMH. Almost half of the TennCare population eligible for Health Link was enrolled in the program. All LTSS members in nursing facilities received services through a VBP model.
- **Delivery Transformation:** Supports for health system transformation included comprehensive stakeholder involvement, training and technical assistance (TA), PCMH and Health Link measure alignment, and implementation of the CCT.
- **Health Information Technology (Health IT):** The CCT provided real-time admission, discharge, and transfer (ADT) data, supported improved quality care, and was used by all PCMH and Health Link providers and regarded as an effective tool.
- **Population Health:** The state established multidisciplinary community-based councils, called County Health Assessments (CHAs), to identify their counties' population health priorities and own the resulting action plan.
- **Sustainability:** TennCare-contracted managed care organizations (MCOs) were responsible for expanding, monitoring, and supporting providers in the PCMH and Health Link programs and for monitoring and calculating risk/gain sharing for the EOC program.

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Findings at a Glance

State Innovation Models Round 2 Model Test

Final Evaluation Report—Tennessee

FINDINGS

- Tennessee's perinatal EOC model had a favorable impact on cesarean sections in its first four years, and its asthma EOC had unfavorable impacts in its first five years. The Medicaid claims-based analyses compared all perinatal and acute asthma exacerbation episodes among Medicaid individuals in Tennessee relative to perinatal and acute asthma exacerbation episodes among individuals in Kansas, Kentucky, and South Carolina.
- Tennessee's Health Link had unfavorable impacts on spending and hospital use, and favorable impacts on behavioral health outcomes in its first two years. The Medicaid claims-based analyses compared Medicaid individuals attributed to and enrolled in Health Link relative to individuals attributed to but not enrolled in Health Link.

TENNESSEE EOC		TENNESSEE HEALTH LINK (Category 1)	
		Medicaid	
Perinatal	☑ C-section: Larger decrease ☒ Post-delivery follow-up within 60 days: Larger decrease	Spending	☒ Total spending PBPM: Larger increase ☑ BH-related total spending PBPM: Larger increase
Asthma	☒ Follow-up visit within the post-trigger window: Smaller increase ☒ Receipt of appropriate asthma medication: Smaller increase ☒ Repeat acute asthma exacerbation: Larger increase	Utilization	☒ Inpatient admissions: Larger increase ☒ ED visits: Larger increase ☑ BH visits: Larger increase

☑ Favorable, statistically significant ☒ Unfavorable, statistically significant ☐ Not statistically different

Note: BH = behavioral health; C-section = Cesarean section; ED = emergency department; PBPM = per beneficiary per month.

KEY TAKEAWAYS

Tennessee's long-standing managed care environment, existing partnerships, and MCO contracts that detailed SIM Initiative participation requirements were critical factors that facilitated robust payer engagement and alternate payment model adoption. Although Tennessee's Health Link and EOC models had largely unfavorable impacts on outcomes, longer analytic timeframes may be needed to fully demonstrate effects. Tennessee was committed to continuing SIM-funded programs beyond the award period through TennCare MCOs and state budget funding.

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Findings at a Glance

State Innovation Models Round 2 Model Test

Final Evaluation Report—Washington

MODEL OVERVIEW

The goals of the Washington SIM Initiative were to move health care purchasing to value-based payments (VBPs) and deliver whole person coordinated care. Three payment and delivery system reforms continued operation past the end of the state's SIM Initiative: (1) Medicaid Integrated Managed Care (IMC) through regional managed care organizations (MCOs); (2) the transition of Medicaid payments to Federally Qualified Health Centers (FQHCs) to reward value rather than volume of services (i.e., per member per month [PMPM]); and (3) an Accountable Care Program (ACP) health benefit option for public employees. A fourth payment model, to better support financially fragile critical access hospitals and other rural providers, was still in development. Other initiatives included a common measure set, a practice transformation hub for providers, data dashboards, and workforce planning.

FINDINGS

- **Payment Reform:** The state's Health Care Authority (HCA) leveraged its purchasing power to advance VBP models through its Medicaid managed care and state employee health plan contracts. Medicaid MCO spending through VBP models increased from 26 percent in 2016 to 75 percent in 2019.
- **Delivery Transformation:** Nine Accountable Communities of Health (ACHs) facilitated regional collaboration in support of delivery system transformation. A SIM-funded practice transformation hub assisted providers in implementing delivery system changes.
- **Health Information Technology (Health IT):** HCA's Analytics, Research, and Measurement Team supported payment model development and produced data dashboards that state agencies and ACHs used in health planning. The HCA established a common measure set from which the agency drew measures that were included in all Medicaid and state employee coverage contracts.
- **Sustainability:** The HCA assumed responsibility for maintaining three payment models. The Medicaid Transformation Project will support both ACHs and continued efforts to increase the use of VBP in Medicaid.

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Findings at a Glance

State Innovation Models Round 2 Model Test

Final Evaluation Report—Washington

FINDINGS

- Washington's Medicaid IMC model had favorable impacts on professional spending per beneficiary per month, emergency department (ED) visits, and behavioral health visits and unfavorable impacts on primary care provider visits in its first two years. The claims-based analyses compared Medicaid beneficiaries enrolled in MCOs in IMC regions relative to similar Medicaid beneficiaries in comparison regions.
- The Accountable Care Network (ACN) model had favorable impacts on ED outcomes in its first three years. The claims-based analyses compared state employees enrolled in ACN regions relative to similar state employees in comparison regions.

WASHINGTON IMC		WASHINGTON ACN	
Medicaid		**UMP – PEBB**	
Spending	☐ Total spending PBPM	Spending	☐ Total spending PMPM
	☐ Total BH-related spending PBPM		☑ ED spending PMPM: Smaller increase
	☑ Professional spending PBPM: Larger increase		
Utilization	☑ ED visits: Smaller increase	Utilization	☑ ED visits: Larger decrease
	☒ PCP visits: Smaller increase		☒ PCP visits: Larger decrease
	☑ BH specialist visits: Larger increase		

☑ Favorable, statistically significant ☒ Unfavorable, statistically significant ☐ Not statistically different

Note: ACN = Accountable Care Network; BH = behavioral health; ED = emergency department; IMC = Integrated Managed Care; PBPM = per beneficiary per month; PCP = primary care provider; PEBB = Public Employees Benefits Board; PMPM = per member per month; UMP = Uniform Medical Plan.

KEY TAKEAWAYS

The state successfully advanced its SIM initiatives through contracting and state legislation. Implementing regional IMC for Medicaid beneficiaries and an ACN health benefit option for state employees were major achievements of Washington's SIM Initiative. Analyses suggest that both models had favorable outcomes. The state used its purchasing power to increase the use of VBP by MCOs and establish ACHs, which supported delivery system transformation and population health planning at the regional level. Regional infrastructures, such as ACHs, offer flexibility and drive local transformation, but challenge statewide coordination. Washington sustained its three main SIM reforms (i.e., IMC, FQHC PMPM payment, and ACNs).

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