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BACKGROUND

The State Innovation Models (SIM) Initiative¹ was launched by the Center for Medicare and Medicaid Innovation (CMMI) in 2012. SIM was a targeted effort to accelerate broad scale development and testing of new service delivery and payment models that have the potential to increase the quality of health care while lowering total costs. As part of their project, participating states committed to leveraging the policy and regulatory levers they possess to support the development of transformative models and increase the pace and breadth of implementation. While the focus is on improving quality of care and reducing costs in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP), the overarching goal is transformation within the broader health care system with state-led, multi-payer payment and delivery system approaches. To qualify for funding, states are required to develop a State Health Innovation Plan (SHIP) utilizing a broad based stakeholder engagement process involving health care practitioners, provider organizations, consumers, insurers, and purchasers from both public and private sectors. To meet this goal, states have established various mechanisms to secure stakeholder input and commitment in the form of SHIP steering committees and project or initiative workgroups.

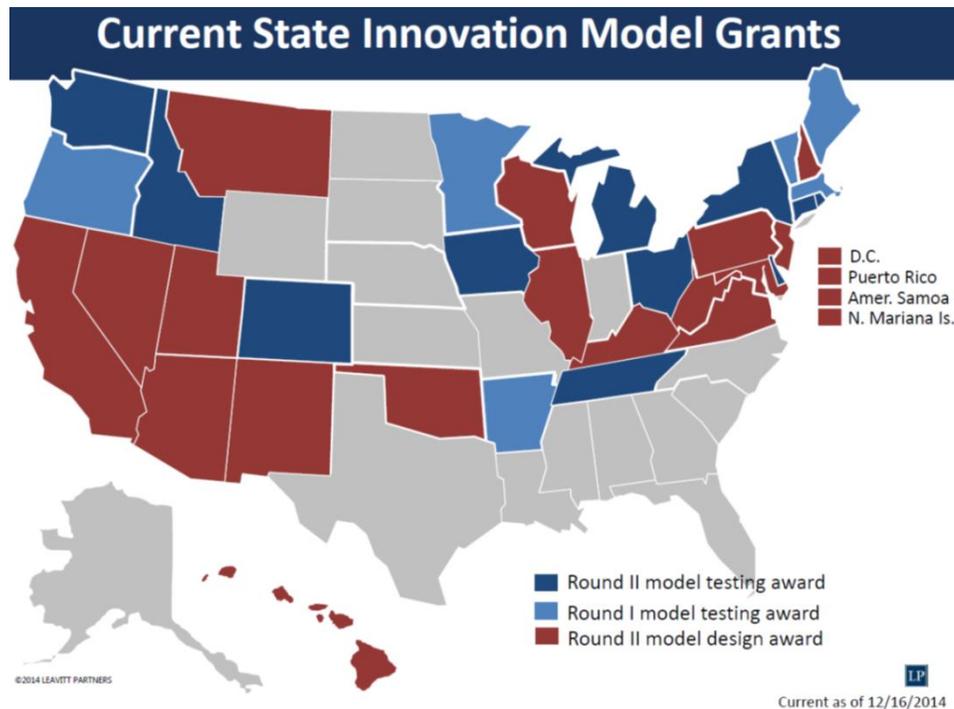
SIM provides financial and technical assistance support to states through two avenues –

- **Design Grants** which support state efforts in developing a SHIP
- **Testing Grants** to support states who are ready to move from design to implementation of their SHIP

Design and testing states also receive technical assistance and support from CMMI for evaluation activities.

Two rounds of SIM funding have been awarded by CMMI. In 2013, 6 states (Arkansas, Maine, Massachusetts, Minnesota, Oregon and Vermont) received testing grants totaling \$253 million. In December 2014, an additional 11 states (Colorado, Connecticut, Delaware, Idaho, Iowa, Michigan, New York, Ohio, Rhode Island, Tennessee, and Washington) received testing grants totaling \$622 million. CMMI also awarded 21 state design grants in 2014 totaling \$42 million. The following map represents states currently participating in the SIM Initiative and the type of award received.

¹ For full details on the SIM Initiative see <http://innovation.cms.gov/initiatives/State-Innovations/>



Since every state is unique in demographics, economics, and politics, there is not necessarily a one-size-fits-all SIM solution. A model may be successful in one state, but have only a minor impact in another. For this reason, states have been encouraged to come up with a plan that will work best for their individual state. Despite this individualization, there are many similarities in the strategies that states have identified as central to their transformation efforts. The strategies are summarized below.

Delivery System. Use of medical home models² is a common delivery approach among the states’ SHIPs. A handful of states are also implementing accountable care models that focus on either the whole population or targeted populations such as recipients of long-term services and supports, patients with chronic conditions, or patients with serious mental health conditions.

Payment Reform. While all states include strategies to accelerate the transition to value-based payment models, the specifics of each state’s model vary. The most common model is a shared savings arrangement, with some states incorporating shared risk and capitation. Other states have transitioned to, or are planning to transition to, episode of care or bundled payments, and a few have opted to give carriers the freedom to implement their preferred payment model or models rather than dictating a specific model.

Behavioral Health Integration. Integration of behavioral and physical health is a core component of state innovation efforts. Strategies include co-locating primary care and behavioral health clinics, incorporating behavioral health metrics, such as screening for clinical depression or initiation and engagement of alcohol and other drug dependence treatment, in performance indicators and payments, and charging multi-specialty care management teams with addressing both physical and behavioral health needs.

² States are using a variety of model principles in developing their medical home models, such as those defined by the Agency for Healthcare Research and Quality (AHRQ), National Committee for Quality Assurance (NCQA), The Joint Commission (TJC), and others.

Workforce. Many state SHIPs include specific strategies to engage and support health care professionals and organizations and to provide the supports they need to successfully engage in practice transformation. In several states, regionally based “transformation” hubs are being developed to assure this support is available statewide. Approaches for training and certifying community health workers are being developed, as well as efforts to integrate them into patient-centered medical homes (PCMHs) and other care delivery models. In addition, some states are expanding provider training to include team-based care strategies.

Community Collaboration. In developing their SHIPs, states recognized the effect that social conditions have on the overall health of a population and, therefore, how critical it is for community based health and social services organizations to be integrated into transformation efforts. Many partnerships are being created among community agencies, providers, and public health departments to coordinate population health efforts and connect clinical health services with relevant community resources within the state.

Consumer Engagement. A few states have specified consumer engagement plans to either incentivize healthy behaviors or support consumers in assuming greater responsibility in choosing the services and supports available to them.

Tools Supporting Transformation. Most states are engaging in efforts to better align performance measures and processes across payers and transformation efforts. States are creating or expanding All-Payer Claims Databases (APCD) and other strategies to aggregate and analyze cost and quality data to inform healthcare policy and practice decisions as well as to provide transparency for consumers. Expanded use of telehealth is also a prevalent component of state SHIPs.

ROLES AND OPPORTUNITIES FOR HEALTH CENTERS³

With the critical role that health centers play in the delivery of services to Medicaid and CHIP beneficiaries, it is no surprise that CMMI expects states to consider both how health centers could support state transformation efforts and how state delivery systems and payment model reforms would in turn impact them. The involvement of health centers and their state Primary Care Associations (PCAs) in the development and implementation of state SHIPs varies across states. A review of Round I and II testing states reveals three areas where health centers are most likely to play a central role in the development and implementation of state transformation efforts.

Delivery Systems Practice Transformation: Health centers have been leaders in transitioning to the PCMH care delivery model. As states seek to expand use of PCMH models of care delivery, health centers are serving as both sites for models of care as well as key elements of a state’s practice transformation efforts within other care delivery settings.

Behavioral Health and Physical Health Integration:

Over the past several years, health centers have received funding to initiate and expand the provision of behavioral health services. States that are focusing on strategies to integrate behavioral health and physical health are looking to health centers as first adopter or pilot sites for implementing models of integrated care.

COLORADO

Colorado will provide support to health centers and primary care practices as they integrate physical health and behavioral health services through three stages of transformation – coordinated services, colocation of services, and integrated services. Using a phased approach to recruitment of practices, the state hopes to move as many individuals as possible to the integrated care stage by the end of the SIM grant period. Health centers will be included among the first set of pilot practices.

³ In this document, unless otherwise noted, the term “health center” is used to refer to Health Center Program grantees, federally qualified health centers (FQHCs), and FQHC Look-Alike organizations, which meet the Health Center Program requirements but do not receive Health Center Program grants.

Payment Reforms: State SIM efforts are heavily focused on the development and adoption of alternative payment models that further the transition from volume based care to value based care. Some states are working with their PCAs and health centers to develop creative methodologies that integrate value based principles and approaches in the context of prospective payment systems and/or alternative payment methodologies (which are integral to the state/FQHC financial relationship). SIM funding is being used for needed consultant services to support these efforts.

CHALLENGES COEXIST WITH OPPORTUNITIES

The SIM initiative has opened opportunities for health centers to play a central role in broad scale healthcare transformation efforts. It is also clear that several challenges exist. States sought more financial support for their SIM efforts than CMMI ultimately awarded, which has reduced the amount of financial assistance that is available to support community providers, including health centers, in actual practice transformation efforts. Additionally, SIM is only one area of transformation that states are involved in and, in several states, determining how SIM “fits” with other initiatives—both those supported through CMMI funding, such as the FQHC Advanced Primary Care Practice Demonstration, and other state/CMS efforts, such as Delivery System Reform Incentive Pool (DSRIP)—is a further challenge.

SUMMARY

The State Innovation Model, which encourages states to leverage their role in spurring statewide health care transformation, has the potential to accelerate movement towards value based care delivery systems and the payment models that support them. In order to assure the maximum benefit from these transformation efforts for the Medicaid and CHIP populations, it is critical that health centers and Primary Care Associations are involved in all aspects of designing and implementing the reforms. While each state’s transformation strategies are unique to their specific demographics, economics, and politics, there are enough commonalities that health centers can maximize their influence by continuing to explore and share experiences within and across state lines.

WASHINGTON

Washington State intends to introduce a value-based alternative payment methodology in Medicaid for federally qualified health centers (FQHCs) and Rural Health Clinics and to pursue new flexibility in care delivery and financial incentives for participating Critical Access Hospitals. These models will test how increased financial flexibility can support promising models that expand care delivery options such as email, telehealth, group visits, and expanded care teams.

CONNECTICUT

Connecticut intends to establish a Medicaid Quality Incentive Shared Savings Program (QISSP) and competitively select Advanced Networks and FQHCs for participation. Support will be offered to participating FQHCs through the Community and Clinical Integration Program (CCIP), which provides technical support to build linkages with community resources and clinical integration capabilities to manage care¹

¹For full details on the CCIP initiative see:

http://www.healthreform.ct.gov/ohri/lib/ohri/sim/steering_committee/2015-03-12/presentation_hisc_ccip_v12_final.pdf or
http://www.healthreform.ct.gov/ohri/lib/ohri/sim/test_grant_documents/application/ct_sim_test_program_narrative_final.pdf

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State Innovation Models (SIM): Roles, Opportunities and Challenges for Health Centers in Statewide Healthcare Transformation

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