CMS.gov
Centers for Medicare & Medicaid Services

State Innovation Model Progress Report

Award Detail

Award Title	Delaware:Test R2	**Round**	2
Organization Name	Delaware	**Grants Management Specialist**	Gabriel Nah
Type	Test	**Project Officer**	Katie Shannahan
Total Funding Amount	$35,000,000.00		
Description	Delaware will: (1) support ten community-based population health programs (Health Communities); (2) develop an IT infrastructure to support a cross-payer scorecard of core measures available to providers with related tools for patient engagement and price and quality transparency; and (3) engage payers in the development of a pay-for-value model and a total-cost-of-care model for providers (including independent PCPs), with the goal of attributing all Delawareans to a primary care provider during the performance period. In addition, the state will offer technical assistance to providers focusing on models of integrated, team-based care and transition to value-based payment models. Delaware will implement workforce development strategies to build competencies and address the current workforce and will also develop educational programs to address the needs of model participants.		

Progress Report

Progress Report	Progress Report 1 - Award Year 4	**Award Title**	Delaware:Test R2
Report Number	1	**Award Year**	4

Approval Status	Pending Approval	**Date Submitted**	5/31/2018
Date Approved		**Last Modified By**	Ann Kempski
Reporting Period Start Date	2/1/2017		
Reporting Period End Date	1/31/2018		
WBS Not Applicable	☐		

Executive Summary

Success Story or Best Practice

The success story for Delaware in Quarter 1 of Year 4 is the progress made by our population health initiative, Healthy Neighborhoods. With new consultants (HMA), and new HCC staff leader (Keanna Faison), intense stakeholder engagement, social network analysis, model development and endorsement, data analysis, and criteria for resource allocation were established at the end of Year 3 and continued through quarter 1 of Year 4. While respecting the groundwork done early in the grant, HMA and HCC are guiding lead stakeholders and Local Councils to make decisions through local task forces, provide technical assistance, prepare proposals, and take them forward to a statewide consortium. The new structures and decision-making processes are instilling confidence in funders within and outside of Delaware's health care delivery system. The local initiatives funded with SIM are evidence-based and targeted to vulnerable Delawareans who are reliant on emergency departments or have other very episodic interaction with the health care delivery system. Support from and integration with social services organizations are required to improve health outcomes for the targeted subpopulations, which include homeless individuals, survivors of violence, and individuals with substance use disorder. Other initiatives are focus on creating safe spaces for play, recreation, and social and community space to promote active living and build community resilience. We are pleased with the initiatives and collaboration reflection in the local initiatives under review.
The sustainability planning for Healthy Neighborhoods has taken shape, and on June 12 key stakeholders will come together to review a plan to create a Community Investment Council that would leverage multiple funding sources and help to scale and align work across the state. SIM funds will be requested to help capitalize this entity and governance model.

Challenges Encountered & Plan to Address

Our Quarter 1 Payment Reform Readiness evaluation, conducted with help of structured interviews of key payer, provider, and ACO stakeholders, revealed continued challenges in readiness and willingness to take risk among Delaware's health system leaders. We have shared the findings of this evaluation with CMMI. Our strategy to address this challenge is to explore using our Medicaid MCO relationships and contracts to promote greater trust, collaboration, and payment reform readiness investments at the payer and practice levels.
In addition, our ongoing work to establish a Quality and Cost Benchmark is meeting resistance among some powerful stakeholders, despite efforts to engage them in a transparent Advisory Committee process facilitated by Mercer and Bailit. However, by conducting detailed, public discussions about the data sources, methodologies, learnings from other states, and step- by- step implementation issues for sustaining an annual benchmarking process, we are effectively creating a sustainability plan as a byproduct of the process.

Governance

We have not made any significant changes to SIM governance at this time. As we prepare carryover workplan we anticipate bringing in additional consultant and temporary staffing support. In addition, our Medicaid and Department of Public Health colleagues will be devoting more time to SIM related priorities, particularly as sustainability becomes the priority. The HCC has added two part-time "casual/seasonal" staff to assist with grant administration and fiscal management.

Stakeholder Engagement

Quarter 1 has included intense stakeholder engagement across all drivers. We continue to convene stakeholders across all of the four drivers, and update the public at monthly Health Care Commission meetings. With support from HMA, we are collaborating with primary care stakeholders to hold a primary care roundtable on June 19, which will be preceded by a consumer focus group. Both discussions will inform recommendations and options to be delivered to the HCC in late 2018. Healthy Neighborhoods stakeholders are coming together on June 12 for a sustainability workshop. We continue to engage the Delaware Center for Health Innovation on all SIM activities, though its role in SIM governance has been reduced. We appreciate the visit by CMMI SIM leadership to Delaware to provide context for the DCHI Board of Directors. The Behavioral Health Integration work led by HMA has built new linkages across behavioral health and primary care providers, and the learning collaboratives have received very high ratings from participants. The Cohort design for BHI also promotes strong peer support and learning. We are seeing emergence of primary care advocacy in form of legislation to require higher rates and track and increase the proportion of total cost of care devoted to PC. This may signal stronger pressure from within the delivery system to accelerate payment reform.

Population Health

see the success story above for Population Health update. In addition to the above mentioned activities, Healthy Neighborhoods held a data webinar which reviewed DE sources of population health and socio-economic and demographic data to assist stakeholders in community-based organizations. HMA also conducted a community health needs assessment alignment exercise.
We have plans in Q2-3 to identify a partner to help organize our population health data in a more user friendly web-based format to serve as a tool and resource for community initiatives and priority setting.

Health Care Delivery Transformation

Practice transformation contracts are ending on 5/31 and we are compiling evaluations. Vendors assisted in Q1 with recruitment of practices to DHIN webinar to feature its tools and services for practices engaging in VBP. We continue to work toward releasing Common Scorecard metrics at state level in demonstration of transparency as enabler of transformation. We are vetting measures internally to understand differences in HEDIS and Behavioral Health Risk Surveillance Survey metrics before we do a public release. We are also collaborating internally to determine if both commercial and Medicaid performance on the Common Scorecard HEDIS metrics can be released publicly at the state level. Behavioral health integration work has generated enthusiastic participation in cohort 1, even better in upcoming cohort 2. Both primary care and behavioral health practices are participating in learning collaboratives and testing the collaborative care model. Formal feedback from practices on the coaching and learning collaboratives has been very positive. Practices express concern about pace of payment reform "catching up" to practice transformation to support and sustain provider efforts and investments. In the short term, BHI leaders would like Medicaid and commercial payers to agree to pay collaborative care codes currently covered in Medicare fee schedule. We hope that those conversations can be encouraged with plans participating in Medicaid and the SEB.

Payment and Service Delivery Models

Mercer conducted structured interviews with range of payers, providers, other stakeholders to assess payment reform readiness, capacity, and willingness. Mercer organized interviews into report to DHSS/DHCC to inform strategy and next steps. Mercer assisted with drafted of Executive Order to create Advisory Committee on Cost and Quality Benchmark, and has staffed that process and secured advise from leading health economist. With Mercer's support, DHSS and DE State Employee Benefits held a coordinating meeting in Q1 and identified potential areas of alignment in expiring contracts, data requests, quality measurement, consulting support, and legislative changes that might be needed. In Q2 and Q3 we plan to meet again to continue to explore areas of closer coordination. In addition, model development work is scheduled to begin with Medicaid in Q2-Q3, which we hope to do with MCO participation. Open enrollment for the SEB plan just ended, and we will be reviewing data jointly with them on plan selection and overall consumer engagement in tools developed and campaign tactics to increase number of active choosers. With carryover, our plan is to invest in a suite of "payment reform readiness" tools and resources that will directly benefit practices to succeed to VBP models. We will solicit feedback from payers, practices, CMMI, and experts on what are highest-impact investments that can begin before end of SIM grant.

Leveraging Regulatory Authority

With Mercer's help we have drafted a memo on DHIN to review history, statute, regulatory and governance issues. This is informing regulatory strategy. Similarly, we are using Mercer's scope of work to review the Health Care Commission's statute and capacity to operationalize and sustain the cost and quality benchmarking exercise of setting and evaluating performance against benchmarks. Materials are available to share with CMMI.

Workforce Capacity

With support from HMA, we are reviewing data on primary care capacity and updating data based on review and evaluation of practices that participated in PT. This will inform the primary care written report to HCC to be presented in late 2018. As we look at payment reform readiness investment opportunities with our carryover funds, we will consider whether any trainings beyond the coaching and BHI we are already providing should be offered. We see growing role of, and more nurse practitioners in primary care; however, we are also seeing competition for mid-levels resulting in these important team members leaving primary care and joining specialty care teams.

Health Information Technology

Our HIT priority for Year 4, building out the Delaware Health Care Claims Database, is showing promise. Our partner, the Delaware Health Information Network, has successfully executed a "proof of concept" linking a small, scrubbed claims file with clinical data in its HIE, and had a very high patient matching rate. The DHIN is now receiving files from the payers and setting up the infrastructure to ingest claims, using Freedman as primary consultant in the project management. DHIN is challenged with "bandwidth" in Year 4 as it is also doing a major tech refresh of its entire HIE platform. As a result, smaller projects that we had hoped to partner with DHIN to execute, have been tasked to HMA (simple registry for BHI practices). In addition, HMA has helped us to get a better understanding of DHIN's capabilities and current business model, which is fee based. At present, DHIN receives no direct state support outside of SIM. HMA has also assisted with preparation of HMA unrestriction in collaboration with DHIN subcontractors.

Continuous Quality Improvement

We appreciate feedback from our state evaluator, and its continuous reporting on stakeholder engagement, perceptions and understanding of SIM work. We continue to hear concerns from certain stakeholders, particularly about whether their input is heard. As a small state, Delawareans have high expectations of frequent direct face-to-face engagement, which is beyond the capacity of SIM leadership to maintain. While stakeholders appreciate the use of social media and formal public comment processes, formal Advisory Group structuctures, and topic or driver specific meetings, they continue to express lack of understanding of SIM "direction". We are making efforts to communicate through multiple channels and be available at multiple "tables", as well as to convene targeted stakeholders on specific topics (i.e. Healthy Neighborhoods sustainability workshop, primary care roundtable, consumer focus group, etc). Our ChooseHealthDE (www.choosehealthde.org) along with the Delaware Health Care Commission remain the primary websites for SIM communications. We have added an "upcoming events" and quarterly newsletter which are sent to a stakeholder list of approximately 2,000.

Additional Information

Metrics

Metric Name	Performance Goal	Current Value

Risk Factors

Risk Factors	Current Priority Level	Current Probability	Current Impact	Prioritized Risk Mitigation Strategy	Current Next Steps	Current Timeline
Confusion among providers between TCPI and SIM funding opportunities	1	Low	Low	n/a	n/a	n/a
Curriculum is not implemented in timely way to support change	1	Low	Low	n/a	n/a	n/a
Elimination of collaborative agreement disconnects APRNs from care team	1	Low	Low	n/a	n/a	n/a
Inability to align on focus area	3	Medium	Medium	We collapsed drivers for Year 4, are coordinating across vendors, and organizing feedback to payers.	try to complete benchmark by end of July	Q1-Q4
Insufficient capacity within DHIN or other agencies to lead HIT initiatives	3	Medium	Medium	We are prioritizing APCD/HCCD with DHIN and looking to diversify other sources for HIT support in short run. Sustainability prioritiy area.	Finalize much delayed DHIN Year 4 contract and unrestriction.	Q2-Q4

Lack of funding for sustainability	3	Medium	Low	Identify funding sources, prioritize activities for sustainability (payment reform and Healthy Neighborhoods high)	exploring options with Mercer, HMA	Q1-Q4
Lack of measurable success for pilot Neighborhood(s)	2	Medium	Low	Build stronger consensus around models, evidence, data sources, which is leading to more measureable success as we initiative small test projects.	n/a	Q1-Q4
Low consumer interest in engagement tools	3	Low	Low	worked with state employee benefit to help promote their tools for 2018-2019 open enrollment; will evaluate in Q2-Q3	release common scorecard in format accessible to consumers	Q2-Q3
Low payer participation	5	Medium	High	see Ops Year 4--Medicaid contracting with MCOs, launch next phase of model development and engagement with ACOs.	Engage MCOs as partners (see CO request)	/q1-/q4
Low provider participation in practice transformation services	3	Medium	Medium	Have made progress in this area. Next phase is to integrate more directly with payment reform.	leverage MCOs in carryover phase of PT/payment reform readiness investments	Q2-Q4

Low provider participation in VBP models	5	Medium	High	Leverage SIM dollars to bring payers and practices together in payment reform readiness investment fund.	engage Medicaid MCOs as partners to prepare practices	Q3-Q4
Messaging does not reach target audience	4	Medium	Medium	Develop capacity and channels for targeted as well as mass communications; leverage social media and partner organizations with good channels.	Refining lists, doing smaller targeted stakeholder discussions, i.e. sustainability planning	Q2-Q4
Stakeholder participation wanes over time	3	Medium	Medium	Maintain focus on fewer, high priority activities and communicate regularly, clearly.	June newsletter release	Q1-Q4
Stakeholders unable to deliver necessary data to produce scorecards	2	Medium	Medium	n/a	n/a	n/a
Vendors unable to deliver HIT functionality on time	4	High	High	Make funding available, take away other SIM distractions to focus on APCD	2X/mo touchpoints with DHIN	Q1-Q4

WBS

Vendor	Category of Expense	Primary Driver	Total Unrestricted Funding (obligated funds)	Metric Name	Carry Over Funds	Rate/ Unit Cost	Comments/ Notes	Total Payments (spent funds)
Concept Systems	Consultation Services		$249,772		No		state evaluator	$31,269
Mercer	Consultation Services	Driver 1	$1,200,000		No		work being done; delay in paying invoices	$0
Health Management Associates	Consultation Services	Driver 2	$2,254,912		No		delay in paying invoices--significant work performed to date on Drivers 2,3, 4	$0
Medical Society of Delaware-MEDNet	Consultation Services	Driver 2	$37,500		No		Practice transformation coaching	$16,000
Remedy	Consultation Services	Driver 2	$150,500		No		Practice Transformation coaching	$66,000
New Jersey Academy of FAmily PHysicians	Consultation Services	Driver 2	$105,000		No			$58,000
AES	Consultation Services	Driver 2	$8,487		No		Practice Transformation evaluation services	$2,537
AB&C communications	Consultation Services	Driver 3	$164,890		No		consumer and public engagement and education--website,	$83,311

e-newsletters,
promotion of
meetings, etc

A federal government website managed by the Centers for Medicare & Medicaid Services
7500 Security Boulevard, Baltimore, MD 21244