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 3 - Award Year 3	**Award Title**	Delaware:Test R2
Report Number	3	**Award Year**	3

Approval Status	Pending Approval	**Date Submitted**	11/30/2017
Date Approved		**Last Modified By**	Ann Kempski
Reporting Period Start Date	8/1/2017		
Reporting Period End Date	10/31/2017		
WBS Not Applicable	☐		

Executive Summary

Success Story or Best Practice

The Delaware Health Care Commission (DHCC) acheived a number of successes during Q3. DHHC supported 4 Health Care Benchmark Summits and 1 Legislative Townhall to engage and receive input from national & local experts, as well as local stakeholders, and prepare for the next legislative phase of operationalizing a health care benchmark. The Department of Health and Social Services additionally released for public input the Road to Value paper reflecting Governor Carney's goals and direction to transform the Delaware health care delivery system and improve health outcomes. After a lengthy competitive procurement, DHCC awarded two new major contracts to: 1)accelerate payment reform and data transparency (Drivers 3, 7, 8), awarded to Mercer; and 2) improve progress to operationalize Healthy Neighborhoods, launch behavioral health integration pilots, and provide overall project and infrastructure support (Drivers 2,5,6), awarded to Health Management Associates (HMA). The Commission held a 1-day "deep dive" on health information technology (HIT) with the Office of the National Coordinator and partners, resulting in a number of future action items and a request for technical assistance. DE SIM leadership and Christiana Care leaders also met with CMMI SIG team during Q3 to learn more about Medicare options for state SIM models.

Challenges Encountered & Plan to Address

Q3 challenges to address: 1) incorporating health care benchmark into overall SIM operational plan and leveraging it to accelerate payment reform; 2) transitioning key activities to new contractors, transitioning and establishing effective relationships among and between vendors as well as stakeholders, and repositioning stakeholder engagement work. We are addressing #1 through integration of cost benchmark work into Mercer contract work plan and engaging in meaningful and effecitive discussions with providers and Medicaid MCOs about moving this work forward together; and #2 through establishing regular, frequent meetings to redefine roles of the Delaware Center for Health Innovation, DHCC and HMA, and broaden stakeholder engagement outside DCHI to include practice transformation vendors, consumer and labor groups, legislative townhalls and other entities and activities. The infrastructure created at DCHI may not be sustainable in its current form/level, and DHCC is exploring options for Year 4 to continue its higher value Committees and convening role. DCHI has not been able to diversify its funding sources to a sufficient level to sustain the activities it supported in the earlier phase of SIM Model test, which involved the production of white papers, the research and design of the Common Scorecard quality metrics, overseeing Healthy Neighborhoods, as well as convening and managing formal stakeholder committee(s) process and structure, and communications. The DHCC is assuming some of these activities more directly (see Benchmark Summits, Road to Value whitepaper), or through new vendors, but also sees continued value in DCHI's convening and stakeholder engagement role.

Governance

Senior staff transitions include transfer of Laura Howard, formerly Executive Director, DHCC, to Deputy at Delaware Department of Aging; hiring of Ann Kempski into Executive Director, DHCC role in September 2017. Ms. Kempski spent more than 7 years at Kaiser Permanente, as Director of Policy for the Permanente Federation, which supports 20,000 Permanente physicians employed in 8 separate multi-specialty medical groups practicing in risk-sharing accountable care arrangements with Kaiser Foundation Health Plan. She assisted in multiple ACA implementation activities, Medicare Advantage payment issues, and MACRA decisions for large integrated delivery system. In November, Helen Arthur, Director of Planning and Policy/PM/Authorizing Official transitioned from DHCC to take a leadership role in DE Department of Public Health. The role of DCHI and its sustainability will be discussed at DCHI Board of Directors meeting during the second week in Dec 2017. Its role in SIM governance is changing to be more focused on convening and facilitating stakeholder communication and engagement, as well as providing valuable expertise from clinicians and other leaders. The Health Care Commission continues to use its monthly meetings to report to the Delaware public and to solicit feedback on SIM activities and health care transformation more broadly. The Commission members actively engage in evaluating SIM activities and are providing guidance to inform our priorities. Overlapping board members of the Delaware Health Information Network, Delaware Health Care Commission, and Delaware Center for Health Innovation help facilitate alignment and coordination.

Stakeholder Engagement

DHSS and DHCC have taken more direct role in stakeholder engagement as required by HJ 7 (the call to establish a benchmark) to develop feasibility plan for health care benchmark in DE. The Summits engaged large in-person audiences, Facebook Live participation, and thousands of "hits" on YouTube, and visits to the DHCC website. The Secretary and her leadership team have done multiple meetings with the hospital association leadership, Medical Society of DE leadership, a legislative Town Hall with 4 legislators, and meetings with consumer advocates, and labor activists. DHCC monthly public meetings include SIM activity updates and public comment. Road to Value paper and upcoming Benchmark paper solicit and respond to public comment. DHCC has developed a list of almost 1,000 stakeholders to inform, engage, and invite feedback from. The new contractors Mercer and HMA are also adding capacity for stakeholder engagement and organizing feedback to DHSS/DHCC. Mercer is focusing on engaging payers and large providers, and HMA is targeting community based organizations and primary care and behavioral health providers, including safety net providers. The DE Legislature's health and budget leaders will be focus of stakeholder engagement beginning in Q4 and Year 4.

Population Health

The transition of Healthy Neighborhood project leadership from DCHI to HMA began in Q3, with discussions on respective roles and collaboration. The HMA Healthy Neighborhoods team efforts-to-date have resulted in: three in-person presentations to members of the State of Delaware Health Care Commission, the DCHI Healthy Neighborhoods Steering Committee (HCC), and the Dover/Smyrna Local Council; a draft work plan that has undergone initial review with HCC; draft communications materials; a fiscal agent application/capacity checklist; a grant fund distribution model; a social network analysis model and accompanying survey; and invitation letter for social network analysis survey participation.

Health Care Delivery Transformation

Practice Transformation: As of September 30, 2017, 108 practice sites and 353 unique providers were enrolled in the practice transformation initiative. We are no longer enrolling new practices. During Q3, DHCC worked with analysts to assess practice readiness to graduate. Assessment includes the number of practices: 1) currently passing all milestones; and 2) enrolled in the program for 24 months by 1/31/18 and 5/31/18. As DHCC prepares for final Year 4, data shows that 86/108 practices will have been enrolled for 24 months by 5/31/18. HMA Behavioral Health Integration team is currently collaborating with Practice Transformation vendors to avoid any duplication of efforts and minimize provider burnout from the two initiatives (practice transformation and behavioral health integration).
Behavioral Health Integration Pilot Program Implementation and Evaluation: Since our kick-off on October 26th, the BH Integration team has been focused on several key areas: development of an overall work plan and timeline with the state; engagement with key stakeholders across the state to identify and better understand the current work with BHI and interest in participation; conducting two informational webinars on November 17th; and preparing a recruitment strategy and follow up plan. Webinar and other information can be found on DHCC website. In addition, DHCC is working with DHIN to prepare a public release of aggregate data from the Common Scorecard early in Year 4. We want to pair the release of quality, consumer experienc and efficiency metrics with the discussion of establishment the health care benchmark, which will be focused on the role of transparency and the need for accurate and timely data to support our heath care value agenda. In addition, CMS released 2016 Medicare ACO/MSSP results during Q3, and Delaware now has all of its 6 acute care hospitals participating in a Medicare MSSP track 1 ACO, with approximately 100,000 beneficiaries assigned to ACO (over 50%).

Payment and Service Delivery Models

Mercer's contract with Delaware for SIM-related payment reform work began on October 19, 2017. For the quarter ending October 31, 2017, Mercer began work with Delaware by attending an initial stakeholder meeting with Delaware leadership and the Delaware Healthcare Association (i.e., hospital association) to hear their concerns and suggestions. Onboarding activities in October 2017 included collaboration with HCC on project planning, budget/contract items, work flow ideas and general communication processes. A formal kick-off/work planning meeting was scheduled for early December. The Mercer team performed initial research and preliminary reviews of recent SIM updates in Delaware and early discussions were held with Delaware staff regarding the need to produce a benchmark report for the Delaware General Assembly. In addition, Mercer is assisting DE with designing an ACO model within our Medicaid MCO contracts. We announced new Medicaid MCO contracts in Q3 (Highmark and AmeriHealth-new) and have general language on VBP that now needs to be specified. See Medicare ACO results above. Christiana Care has rolled out Carelink, a centralized care coordination service for ACO participants that leverages DHIN data as well as team-based care delivery to support small practices. Christiana Care developed this service out of 2012 CMMI Innovation Grant.

Leveraging Regulatory Authority

DHSS is in negotiations with Medicaid MCOs (with assist from Mercer) to include stronger VBP models that go beyond current upside only/primary care only approach, is contracting with new Medicaid MCO and re-newing contract with one incumbent. The health care benchmark feasibility paper offers new and stronger potential levers of accountability and transparency. DHSS is preparing 1115 waiver renewal at end of 2018 to include payment reform lever. The DE State employee plan (GHIP) is readying for April-June open enrollment campaign to nudge enrollees to engage with new price transparency tools and disease management and wellness options. New regulatory lever allows GHIP to default enroll enrollees who don't make active choice during OE. The DHCC and Department of Insurance are finalizing 2019 QHP standards, updating the telehealth definition to include home as eligibile site of service. DHCC is leveraging its certificate of need (DE Health Resources Board) authority to promote greater transparency and public accountability for value oriented health care capital projects. DHIN has published its data submission regulation, and drafted data access regulation for Health Care Claims Database in Q3.

Workforce Capacity

In Sept. 2017, two SIM workforce activities were terminated. The UD Learning/Re-learning Curriculum project (with Modules 1-3 completed) and the workforce capacity planning project. We also are not moving forward with Graduate Medical Consortium described in Year 3 Ops plan. In accordance with guidance from CMS, DE is modifying current and future deliverables under SIM to align more directly with purpose and commitment to use a range of regulatory, payment, and policy authorities to drive transformation to improve health and health care costs. As a strategy, these workforce initiatives were not performing in a manner to achieve the desired outcomes; DHCC requests to shift these resources to strengthen payment reform efforts as we head into Year 4. DHCC has launched delayed SIM supported BHI pilot (partnering with HMA) in Q3 to expand workforce capacity to serve more Delawareans with behavioral health needs. HMA to advise DHSS/DPH on feasibility, sustainability of Community Health Workers (Healthy Neighborhoods) during Q4. DHCC is also planning to increase marketing efforts of State Loan Repayment in HPSAs to address maldistribution (non-SIM funding).

Health Information Technology

Several activities progressed in Q3, including drafted data submission and access regs for Health Care Claims Database (HCCD), and a request was formally made to Medicare/CMS for data feed. DHIN was delayed but did onboard a contractor with expertise in HCCD. DHIN confirmed in Q3 that patient portal and DMOST advanced care planning tool both complete, but need promotion among providers, patient community. DHIN has marketing plan launching Q3, Q4 Year 3. DHCC to integrate DHIN tools more deliberately in benchmark, payment model outreach efforts. DHIN preparing Q4 release of Common Scorecard data to providers, with 2016 data. DHCC planning public release of aggregate CS measures (or subset) as companion to cost benchmark, with TA from Mercer and DHIN, engaging DCHI Clinical Committee for its input. DHIN is successfully moving multiple projects while also transitioning to new clinical data platform, but underestimated the time needed for the technical and policy aspects of HCCD. DE's behavioral health EMR pilot involves 4 practices (1 dropped out due to issues with EMR vendor); 2/4 have successfully integrated with both DHIN and at least one primary care practice. The other two practices, which are smaller, have not yet met the integration milestones and have requested extensions. DHCC to ask HMA and ONC to advise on role of BH EHR in overall BH integration strategy in Q4 after assessing overall capacity and readiness of practices. In its Q3 report to its Board of Directors, DHIN reports successfully developing more revenue generating products and services in effort for sustainability.

Continuous Quality Improvement

Concept Systems provided valuable background to onboard new DHCC ED in Q3, particularly related to Healthy Neighborhoods. CS provided both onsite and telephone briefings, and its information gathering process provides timely reports and insights to DHCC. CS' regular interviews with key stakeholders and partners enables DHSS/DHCC leaders to receive valuable feedback that can be incorporated into work plans.

Additional Information

Note--we want to update our risks to reflect our new activites, particularly those related to the health care cost benchmark, but could not figure out how to revise the risks.

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	We decided to terminate this activity after 3 modules and invest resources in higher impact activities.	n/a	Activity terminated Q3 Year 3
Elimination of collaborative agreement disconnects APRNs from care team	1	Low	Low	None currently	none	N/a
Inability to align on focus area	3	Low	Medium	Inability to align or ineffective structure and process to build consensus inhibited decision-making. New contractor HMA to re-structure and streamline processes, introduce new model, and assess readiness to execute action plans.	Assessments, recommendations to be made to HCC by HMA	By end of Q4 Year 3

Insufficient capacity within DHIN or other agencies to lead HIT initiatives	3	Low	Medium	DHIN has brought on consultant resources (Freedman) to assist with Health Care Claims Database, also updating clinical data platform. DHIN staff enrolling in training and certification programs.	Assess whether to sunset some DHIN activities to free up resources for HCCD testing, building new analytical capabilities.	Q4 Year 3 publishing regulations and sub-regulatory guidance related to HCCD.
Lack of funding for sustainability	3	Medium	Medium	Incorporating sustainability criteria into activity assessments; asking HMA to assist with environmental scan of local funders for Healthy Neighborhoods.	Discussion with DCHI on its future development plans; HMA scans local organizations.	During Q1 & Q2 Year 4
Lack of measurable success for pilot Neighborhood(s)	3	Low	Medium	Bringing in new contractor, Health Management Associates, with experience and capacity to execute action plans.	HMA meeting with stakeholders in all 3 HN structures, making assessments.	Year 3 Q4 recommendations
Low consumer interest in engagement tools	2	Low	Low	More sustained consumer engagement needed; DHIN to launch marketing plan focused on consumer audience.	DHIN to launch marketing plan; DHIN to work with HCC and TA vendor to release aggregate Common Scorecard to public.	Q1 of Year 4

Low payer participation	4	Medium	High	New vendor Mercer to provide more capacity for DE as purchaser/payer to negotiate more aggressive progression to TCC payment models.	Design ACO model for Medicaid MCOs; identify possible new waiver authorities for expiring Medicaid 1115 (end of 2018);explore Medicare alignment strategy	Q4 Year 3 to finalize Medicaid ACO model; prepare 1115 renewal during Year 4 Q1-2).
Low provider participation in practice transformation services	2	Low	Low	Identify multiple sources of practice transformation support (Medicare ACOs, Medicare QIOs, EHR vendors, trade and professional ass'ns, as we wind down SIM supported PT.	Provide warm hand-offs of participating practices to HMA as they prepare to launch BHI.	Wind down by Q1 Year 4, with some practices "graduating" to behavioral health integration pilot.
Low provider participation in VBP models	3	Medium	Medium	Negotiate Medicaid ACO model with Medicaid MCOs. Try to leverage Medicare ACO growth in DE, and MACRA requirements to nudge more providers into VBP models.	Work with Mercer on Medicaid ACO design, do deep dive with Mercer to look at independent PC practice viability in DE.	By early Q1 Year 4

Messaging does not reach target audience	2	Low	Medium	New administration making full use of social media, building lists, coordinating across public and private stakeholders more effectively; invest more resources in Patient & Consumer Engagement	Build consumer campaign around Common Scorecard release, link to Benchmark report rollout. More meetings with consumer representatives to understand their priorities, concerns.	Q4 Year 3; Q1 Year 4
Stakeholder participation wanes over time	1	Low	Low	Ongoing engagement, both formal and informal; incorporating feedback and demonstrating responsiveness to concerns when appropriate.	Assess future role of DCHI, already compensating for its likely smaller role in Year 4.	Q4 HMA engaging stakeholders intensely on Healthy Neighborhoods, Behavioral Health Integration; Q4 DHSS/HCC engaging on Benchmark
Stakeholders unable to deliver necessary data to produce scorecards	1	Low	Low	This is not currently a risk factor.	DHCC exploring public release of aggregate Common Scorecard; data appears to be good enough for release 1.0.	Q4 or Q5 of no-cost extension period.

Vendors unable to deliver HIT functionality on time	3	Medium	Medium	Seeking ONC TA and other TA where we can find it.	DHIN transitioning to new clinical data platform Q4 Year 3; may cause delays but will have greater functionality, particularly analytic, and at lower cost. HCCD new function will be tested slowly over time.	HCCD to have ability to test data feeds from select payers in Q2 of Year 4.

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	Contract		$249,881		No		Contracted state-led evaluator	$90,000
ab+c Creative Intelligence	Contract	Driver 1	$300,000		No		Website build, maintenance; communications strategy	$45,509
Health Management Associates	Contract	Driver 2	$1,297,855		Yes		Driver #2 Healthy Neighborhoods; Driver #6 Behavioral Health Integration; Infrastructure and program management	$0
NJ Academy of Family Physicians	Contract	Driver 3	$420,000		Yes		Practice transformation technical assistance/coaching	$90,000
MedAllies	Contract	Driver 3	$300,000		Yes		Practice transformation technical assistance/coaching	$60,562
DE Medical Society	Contract	Driver 3	$264,000		Yes		Practice transformation technical assistance/coaching	$66,000
Remedy	Contract	Driver 3	$504,000		Yes		Practice transformation technical assistance/coaching	$110,000

Mid-Atlantic Behavioral Health	Contract	Driver 3	$15,000	No		Second and final payment for behavioral health EHR connectivity	$7,500
University of Delaware	Contract	Driver 4	$158,000	No		Contracted vendor for workforce curriculum; project terminated in Q3	$81,267
travel	Other	Driver 6	$4,069	No	GSA	speaker travel for benchmark Summits	$2,464
Mercer	Contract	Driver 7	$889,947	Yes		Drivers #3 Implement patient centered medical homes and ACOs #7 Promote introduction of VBP models across payers and monitor implementation.	$0