State Innovation Model Annual Progress Report

April 30, 2018

Table of Contents

Acronyms and Abbreviations Used in AY3 Annual Report		
Acronym	**Meaning**	**Description of Term or Reference**
ACO	Accountable Care Organization	Refers to Medicare ACOs participating in the Medicare Shared Savings Program
APS	Average Practice Scores	Refers to the calculations made for the Monthly Progress Reporting Tool
AY	Award Year	Refers to SIM years
AY3	Award Year 3	Refers to the period: February 2017-Janary 2018
AY4	Award Year 4	Refers to the period: February 2018-Janary 2019
BHI	Behavioral Health Integration	Refers to Delaware's major strategy under SIM to promote integration of primary care and behavioral health
DCHI	Delaware Center for Health Innovation	Refers to the entity responsible for oversight of the SIM in AY2, with an emerging new role in AY3, as new vendors came on board
DE SIM	Delaware State Innovation Model	Refers to the CMMI five-year State Innovation Model (SIM) grant for Delaware strategies to achieve the Triple Aim Plus One
DHSS	Department of Health and Social Services	Refers to the state department that is responsible for Medicaid, public health, behavioral health and social services
DMMA	Division of Medicaid and Medical Assistance	Refers to Delaware's Medicaid program (part of DHSS)
DHIN	Delaware Health Information Network	Refers to the organization established in 1997 to facilitate health information exchange, and given statutory authority in 2015 to develop and maintain a claims database in DE
EMR	Electronic Medical Records	Refers to the Behavioral Health EMR Assistance Program
FI	Fiscal Intermediary	Refers to the FI established to support the Healthy Neighborhood strategy and to pay engaged organizations providing services and interventions
GHIP	Group Health Insurance Program	Refers to Delaware's Group Health Insurance Program for state employees
HCC	Health Care Commission	Refers to Delaware's public-private entity reporting to the Governor and General Assembly and currently administering the SIM grant.
HCCD	Health Care Claims Database	Refers to the term used in SB 238, which is the legislation authorizing the creation of the HCCD
HIT	Health Information Technology	Refers to the HIT SIM initiatives
HMA	Health Management Associates	Refers to the vendor hired in AY3 to provide project management, and other services

Acronyms and Abbreviations Used in AY3 Annual Report		
Acronym	**Meaning**	**Description of Term or Reference**
HMO	Health Maintenance Organization	Refers to the Group Health Insurance Program HMOs
HNC	Healthy Neighborhoods Committee (HNC)	Refers to the committee tasked with the responsibility to create healthy neighborhoods
HN	Healthy Neighborhoods	Refers to Delaware's major strategy under SIM to create healthy neighborhoods
MCO	Managed Care Organization	Refers to the Medicaid Managed Care Organizations (MCOs)
MPRT	Monthly Progress Reporting Tool	Refers to the tool used by vendors to score practices across 27 sub-criteria using a three-category scale to measure the progress of practices against milestones
MSSP	Medicare Shared Savings Program	Refers to Medicare ACOs participating in the MSSP
OEP	Open Enrollment Period	Refers to OEP for state employees
PCAC	Patient and Consumer Advisory Committee	Refers to the committee that represents patient and consumer perspectives
PCMH	Patient Centered Medical Home	Refers to the National Committee on Quality Assurance on Quality Assurance's PCMH certification program
PCS	Percentage Change Scores	Refers to the calculations made for the MPRT
PMPM	Per Member Per Month	Refers to capitated payments (sometimes called pre-payments) to health plans or providers, in contrast to fee-for-service payments; PMPM facilitates shared risk arrangements.
PT	Practice Transformation (PT)	Refers to DE's support for its practices
RESDAC	Research Data Assistance Center	Refers to CMS entity proving data and technical assistance to researchers; DE made application to ResDAC for DE Medicare data file for HCCD
SB 238	Senate Bill 238	Refers to the legislation, which called for the implementation of a Health Care Claims Database (HCCD) in DE, and became a law signed by Governor
TPA	Third Party Administrator	Refers to the Medical TPA established to pay claims for self-insured entities
VBP	Value-Based Payment	Refers to payment reforms that incorporate accountability for cost and quality and reduce incentive for increasing volume.

A. Overview

Award Year 3 (AY3) of Delaware's State Innovation Model Test Cooperative Agreement (February 2017 through January 2018) represented Delaware's second year of implementation. During AY3, the Delaware Health Care Commission (HCC) remained focused on the Triple Aim Plus One: better health, improved health care quality and patient experience, lower growth in per capita health care costs, and an enhanced provider experience that promotes patient engagement.[i]

The following report provides a summary of Delaware's AY3 accomplishments and challenges, as well as an outlook for AY4 to continue to drive transformation of Delaware's payment and care delivery system, advance value-based payment models, and to ensure the sustainability of SIM initiatives.

Several reports were used to inform and shape the development of content for this report, including publicly-available reports, presentations, working papers, operational plans, evaluations, and monthly and quarterly reports prepared by the Department of Health and Social Services (DHSS), and the HCC and its vendors including: the Delaware Center for Health Innovation (DHCI), Health Management Associates (HMA), Mercer, Inc. (Mercer), and Concept Systems, Inc. (CSI).[ii]

B. Action Steps to Reinvigorate Delaware's SIM

A new governor and Secretary of Health and Social Services were sworn in at the beginning of AY3, and remain committed to the Triple Aim Plus One goals of Delaware's SIM grant. At the direction of Governor Carney, DHSS Secretary Kara Odom Walker, MD reviewed the strategies, activities, investments, and progress made in SIM Years 1 and 2. In September, Governor Carney appointed Ann Kempski as Executive Director of the Delaware Health Care Commission, and she is collaborating closely with Secretary Walker and Commission Board Chair Nancy Fan, MD to organize and execute the SIM activities and initiatives.

With concern over the pace of transformation and the return on investment of certain SIM activities, DHSS and HCC collaborated to re-scope, refocus and accelerate certain activities in order to produce greater progress in transforming Delaware's health care delivery system from volume to value. Under Delaware state procurement rules, however, the decision to re-procure services and support created interruption and delayed the launch of some new activities.

A reflection of this new energy and direction of Delaware's SIM was the enactment of language in the Fiscal Year (FY) 2018 budget bill calling on the DHSS Secretary to report on the feasibility of establishing a health care spending benchmark. New data from the CMS Actuary showing

Delaware's status as the third highest per capita health care spending state highlighted the persistent challenge of high state health care costs, while a new report from America's Health Rankings reminded state policymakers and stakeholders that the high spending is not producing satisfactory outcomes in population health or delivery system performance.

C. Summary of Accomplishments and Milestones

Despite the delays in launching SIM activities caused by re-procuring key consulting services, DHSS and HHC maintained a diligent focus on implementing the State Innovation Model (SIM) activities. The addition of HMA to assist with program management in late AY3 helped HCC and all of its vendors to:

- Strengthen needed operational infrastructure to support the overall SIM program;
- Engage stakeholders in active and meaningful activities;
- Advance delivery transformation and payment reform;
- Leverage regulatory authority;
- Revamp strategies to strengthen the workforce; and,
- Proceed to refine and focus efforts to advance all SIM objectives and milestones across all areas including health information technology.

In AY3 Q4, DHSS Secretary Walker and the Delaware HCC used SIM resources to hold multiple benchmark "summits" where national and state experts came together to share experience with establishing a health care cost benchmark. Following these summits, DHSS and HCC delivered a draft feasibility report to the General Assembly's Joint Finance Committee that included extensive public feedback. These benchmark summits contributed to the case for change in Delaware, including a change in scope and focus of the SIM strategies and activities. Finally, the Payer and Purchaser Summit for January 2018 reinforced the renewed commitment to leveraging the SIM payment reform driver in Delaware.

INFRASTRUCTURE

Actions to Strengthen Operational Structure.

HCC took several important steps to create a new operational structure, to refine its use of resources, to augment its capacity by hiring new vendors, and to create an efficient and streamlined executive-level decision-making process to support implementation. HCC worked closely with the Centers for Medicare and Medicaid Innovation (CMMI) to identify key lessons learned and to develop best practices for supporting a stronger implementation plan.

As part of this plan, HCC added critical new resources by hiring HMA and Mercer to provide a range of services and expertise to augment the capacity of the HCC and the Delaware DHSS to implement DE SIM activities. In AY3, HCC secured the expertise and right level of supports needed to drive sustainable transformation; and, as a result, HCC has been able to kick SIM strategies from low gear into high gear. Healthy Neighborhoods (HN), the Behavioral Health Integration (BHI) program, and payment reform activities have moved fast forward. The organization is well positioned for AY4.

Outlook for AY4.

The outlook for AY4 is extremely positive and energized around implementation, and the sustainability of reform. HCC will leverage the strong foundation built in AY3 and its sharp focus on the Triple Aim Plus One. HCC – with and through its vendors – will continue to engage stakeholders, and to pursue all transformation activities in a "hands-on" manner. There is a renewed focus on achievement, due to HCC's commitment in AY3 to adding the necessary level of expertise and resources to orient the organization around implementation.

STAKEHOLDER ENGAGEMENT

In AY3, HCC made a concerted effort to improve the quality of stakeholder engagement to better align engagement with implementation goals. The additional resources secured through HMA and Mercer helped HCC to engage stakeholders in an action-oriented agenda, and provide direct, "on the ground" resources to communities, providers and others.

The actions taken to broaden stakeholder identification and use open, well-publicized events and comment opportunities improved the quality of stakeholder engagement, as stakeholders can participate and contribute to the progress that is being made. HCC, and its vendors, are now asking stakeholders to participate in fewer committees, and to engage in "standing up" the new initiatives. At the same time, the HCC used its monthly meetings, which are open to the public and allow for public comment, to continuously inform stakeholders about SIM-related activities and initiatives. The SIM stakeholder engagement process went from five to two committees, which provided greater clarity of purpose and function for stakeholders. Over the course of AY3, for example, the meeting agendas for the Healthy Neighborhoods model evolved from an agenda focused around design and planning to planning and implementation. By the end of AY3, stakeholders were engaged to the "vet" the proposed model and plan for implementation.

Outlook for AY4.

HCC has aligned the stakeholder engagement process with the implementation process. The change in priorities, focus, and more open stakeholder process, however, generated anxiety

and dissent among some stakeholders. All stakeholders, including consumers, know and appreciate that they have a "voice" in the decision-making process and a "seat at the table." HCC knows and appreciates that transformation is not sustainable without engaging stakeholders, who have a shared commitment and understanding of the role that they play in achieving the Triple Aim Plus One. Overall, HCC can see the increased level of stakeholder excitement through the increased numbers of attendees, and increased rates of attendance among stakeholders. In addition, the volume of written public comment in response to the quality and cost benchmark initiative indicates broad interest in the overall Road to Value.

In an ongoing communication effort to be as inclusive and transparent as it re-focuses some SIM activities and priorities, the HCC has been revising its stakeholder lists, increasing its use of social media and Facebook Live, and employing both targeted communication strategies and broad dissemination of a new newsletter reporting on a range of SIM related activities and highlighting collaboration, called the *Road to Value*.

Both the Delaware HCC and the Choose Health DE websites are regularly updated for targeted audiences.

POPULATION HEALTH: HEALTHY NEIGHBORHOODS

Healthy Neighborhoods Model.

In December 2017, HMA presented Delaware's Healthy Neighborhoods (HN) Model. The model was approved by HCC and stakeholders. and served to advance the development of this initiative.

The model includes three clear components: (1) a readiness assessment for healthy neighborhoods to help neighborhoods to prepare a proposal; (2) the formation of a statewide consortium to serve as the "sounding board" for communities; and, (3) an approval process that depends upon Local Council approval. This model also includes a clear and easy three-step process for helping three neighborhoods to fast forward with their plan.

To facilitate the development of this initiative, HMA has offered to serve as interim fiscal intermediary (FI) to distribute funds directly to community organizations based on approved Healthy Neighborhood proposals approved by CMMI. HMA is currently working with CMMI to seek approval of the projects proposed by one of the three Healthy Neighborhoods.[1]

[1] Note: HCC's three existing Healthy Neighborhoods are consistent with the original plan to create ten Healthy Neighborhoods. The change in counting convention reflects the decision to create a county-based model that is

Outlook for AY4.

In AY4, HCC is moving full-steam ahead to implement Healthy Neighborhoods. An effort is already underway to identify the interest, qualifications, and eventual selection of an entity who will assume the responsibility to distribute funds to providers supporting the Healthy Communities. HCC with support from HMA will release a request for information, followed by a request for responses (RFR).

HEALTH CARE DELIVERY: CLINICAL/DELIVERY TRANSFORMATION

Practice Transformation: Measuring Progress to Date.

Over the course of AY3, the number of practices and providers enrolled in Practice Transformation (PT) has been stable and represents over one-third of Delaware's primary care physicians. The following table provides a count of practices and providers participating in PT activities.

The continued investment in, and commitment to practice transformation in AY3 coincided with a rollout of a new value-based payment program for primary care practices from Highmark Delaware, known as True Performance. Together, with the robust participation of Delaware hospitals and practices in the Medicare MSSP ACO program, the rollout of a more coherent VBP program from Delaware's largest commercial and Medicaid plan provided a stronger business case for investing in practice transformation coaching and infrastructure.

Practices and Providers Participating in Practice Transformation Activities			
Enrolled	**February 2017**	**January 2018**	**AY3 Change**
# Practices	103	106	+3
# Providers	339	351	+12

Source: DHSS, based upon information from AY3 MPRTs.

During AY3, participating primary care practices made significant progress against Practice Transformation (PT) milestones. Progress is measured by average practice scores (APSs), which are calculated monthly based on vendor-reported data, accompanied by vendor-reported qualitative data.

The following table presents a summary of the overall score or the average score for 106 practices. Two sets of scores are provided. The first set for the first month of AY3; and, the

made up of neighborhoods. There are three counties in Delaware. Three such neighborhoods have emerged from within this structure, with more neighborhoods to follow in Delaware's future.

second set for the last month of AY3. The scores shown are out of a total score of 3.00, which is how a practice is scored. A 3.00 indicates that a practice is fully performing the associated activities. (Note that AY3 represents the first year for which we have data for an award year in this format.)

Average Practice Scores for Award Year 3 (AY3)				
Milestone # and Description		**APS for February 2017**	**APS for January 2018**	**Percentage Change: Feb. 2017-Jan. 2018**
Milestone 1	Identify 5% of the panel that is at the highest risk and highest priority care for care coordination	2.36	2.78	18%
Milestone 2	Provide same-day appointments and/or extended access to care.	2.64	2.86	8%
Milestone 3	Implement a process of following up after patient hospital discharge.	2.56	2,84	11%
Milestone 4	Supply voice-to-voice coverage to panel members 24/7 (e.g. patient can speak with a licensed professional at any time)	2.40	2.77	15%
Milestone 5	Document sourcing and implementation plan for launching a multi-disciplinary team working with highest-risk patients to develop a care plan	2.02	2.71	34%
Milestone 6	Document plan to reduce emergency room overutilization	2.36	2.86	21%
Milestone 7	Implement a process of contacting patients who did not receive appropriate preventive care	2.26	2.55	13%
Milestone 8	Implement a multi-disciplinary team working with highest-risk patients to develop care plans	1.85	2.42	31%
Milestone 9	Document plans for patients with behavioral health care needs	1.87	2.14	14%

Source: DHSS.

Notes: Average Practice Scores (APSs) are calculated by the HCC for DCHI Clinical Advisory Committee to assess: (1) how practices currently measure against PT milestones; and, (2) the level of progress that practices have made towards milestones over the past year.

Legend = Top 3 highest scores among enrolled practices.

As APS scores by milestone indicate, enrolled practices, collectively, scored highest on Milestone 2, *(Provide same-day appointments and/or extended access to care)* and Milestone 6 (*Document plan to reduce emergency room utilization*); both milestones had APS scores of 2.86 out of 3.00. Milestone 3 (*Implement a process of following-up after patient hospital discharge)* has an APS score of 2.84 out of 3.00).

Equally important, however, practices made significant progress from the start to the end of the year as measured by the percentage change in scores from February 2017 to January 2018. APS scores increased by more than 30 percent for Milestone 5 (Document sourcing and implementation plan for launching a multi-disciplinary team working with highest-risk patients to develop a care plan), and Milestone 8 (Implement a multi-disciplinary team working with the highest-risk patients to develop care plans).

Behavioral Health Integration Launch.

HCC launched the Behavioral Health Integration (BHI) initiative in AY3. The work to launch the BHI occurred throughout the award year, culminating in the official launch of the initiative in November 2017 (Q4) with the support of HMA and its clinical team of experts. The first part of the year focused on the development of relationships and engagement. The latter part of the year focused on the launch.

To launch the BHI, the HMA team met with and presented to state leaders, delivery systems leaders for primary care, behavioral health, and HIT to engender a good will about the BHI and to encourage providers to fully participate in the BHI Pilot Program. The "official" launch to providers included a clear explanation of Delaware's approach to develop and implement a strategy to promote integration of primary care and behavioral health, which is twofold: (1) to offer several options to pilots along the continuum of behavioral health integration; and, (2) to work with Delaware clinics wherever they are starting from and to help them to adapt and enhance what is already working. Practice pilots may include: (1) enhanced referral; (2) co-location; and, (3) the Collaborative Care Model, an evidence-based model for supporting patients with behavioral health needs in primary care, and integration of primary care into behavioral health settings. HMA will provide a range of technical assistance to practices sites that are implementing a BHI pilot.

In AY3, the HCC continued to partner and consult with the Clinical Committee of the Delaware Center for Health Innovation (DCHI), a multi-disciplinary committee of clinicians who have been engaged in Delaware SIM from its inception. The DCHI Clinical Committee provides feedback,

expertise, and support for practice transformation and related activities in payment reform, HIT, and quality measurement, and will continue to be an important stakeholder consulted in AY4.

Outlook for AY4.

The outlook for PT and BHI is strong. HCC has deployed a team of expert consultants to the field to work side-by-side with practices and providers to transform the care delivery system around the Triple Aim Plus One, and prepare practices and providers to sustain reform beyond AY4. HCC has established the BHI pilot program and includes two cohorts. Cohort 1 started in January with 14 practices, and will run from January-June. HMA has assigned coaches to the practices, and performed baseline readiness assessments. Cohort 2 will begin in July and run through December. The outlook is very encouraging, and the pilots are taking shape around the 14 participating practices. The 14 practices include seven primary care practices and seven behavioral health practices. Examples of the work priorities are how to support the practices around implementation of Behavioral Health-Electronic Medical Record (BH-EMR) Assistance program and the development of Health Information Technology (HIT) systems.

In AY4, HMA will continue to provide technical assistance to practices and to identify areas for further integration along the continuum of pilot options. Practice participation levels in learning collaboratives and webinar events are high. HCC and HMA will work closely together to develop learnings and best practices from providing technical assistance to Cohort 1 to improve the technical assistance, to engage practices, to build partnerships between PC and BH practices to create systems, and start to develop a statewide registry and BHI scorecard.

In July, HCC will move forward with the practices included in Cohort 2, with the goal to achieve a level of participation that is either equal to or greater than the number of practices enrolled in Cohort 1. HCC also hopes to observe an overall increase in measurement-based care within the practices. On a statewide basis, HCC has three clear priorities: (1) to increase collaboration between practices; (2) to develop and implement a scorecard for long-term measurement; and (3) to continue to streamline activities and planning around supporting practice transformation with the right value-based payment models. As with all other SIM activities, HCC is committed to the long-term sustainability of practice transformation, and will address this directly through its sustainability plan to CMMI.

The HCC, with support from HMA, will also partner with the DCHI Clinical Committee to sponsor a primary care workgroup that will be made up of a small group of clinicians who will review more recent data and trends in Delaware, including learnings from SIM practice transformation evaluation, and consult will a broad cross-sector group of stakeholders. After such consultation

and data analysis, the workgroup will draft a series of options and recommendations to strengthen primary care in Delaware.

PAYMENT REFORM AND PAYMENT MODELS

The long-term sustainability of Delaware's transformation goals and the Triple Aim Plus One is inextricably linked to the degree of payment reform and types of payment models that the health care industry of payers, providers and providers are willing to implement. HCC has made payment reform an on-going priority across award years, with a heightened focus on engaging providers to participate in payment reform in AY3 with the support of its vendor, Mercer, and its subcontractor, Bailit Health.

Value-Based Payment Models Adopted by Providers.

Payers and providers, alike, remain committed to advancing value-based payment (VBP) models that are critical to the long-term sustainability of reform in Delaware. Unsatisfied with the pace of adoption of models that move toward two-sided risk and total cost of care, DHSS leaders used the Medicaid MCO procurement process in AY3 to require more aggressive approaches to sharing risk at the provider level from the two MCOs selected. The timeline for moving to two-sided risk arrangements, as well as the quality measures that will be monitored, can be found here.

Similarly, the Delaware Group Health Insurance Program (GHIP) used the opportunity presented by re-bidding its third-party administrator contract in SIM Year 2 to attract a value-based Health Maintenance Organization (HMO) arrangement from Aetna and Christiana Care. This model does not appear to put the state's largest hospital system at any downside risk. (AY3) was first open-enrollment period (OEP) during which new HMO was offered.) To date, however, there has not been much migration (less than 20%) from the traditional PPO in the GHIP to the new HMO option.

The state's re-invigorated efforts on payment reform coincided with Highmark Blue Cross of Delaware's roll out of a standardized VBP model (across all its markets in WV, PA, DE) focused on primary care. Known as True Performance, the model includes per member per month payments which are reconciled to quality and cost metrics at the end of the year. There is significant overlap with the Delaware Common Scorecard metrics.

Based on a report from Highmark Delaware, which has over 60 percent of the market share in the commercial and Medicaid markets, more than one-third of primary care practices are enrolled in their True Performance VBP program, affecting about one-third of all commercial members, and about 25 percent of all Medicaid members. True Performance is a Category 2C payment model, based on the Learning Action Network (LAN) Alternative Payment Model

framework.[iii] Category 2C reflects a Pay-for-Performance payment model. In addition, Aetna uses a Patient-Centered Medical Home (PCMH) program with its primary care network in Delaware.

Delaware hospitals and practices have enrolled in the Medicare Shared Savings Program (MSSP). All five of Delaware's adult acute care hospitals participate in MSSP, and there are two additional physician-only Medicare Accountable Care Organization (ACO) arrangements in Delaware. Through 2017 reported results, none of the MSSP ACOs in Delaware has yet generated shared savings.

Delaware's Road to Value.

In 2017, DHSS prepared the *Road to Value*, which includes recommendations or interconnected strategies for the State of Delaware, which are designed to transform health care and improve health in Delaware. The landscape of health care payment and policy is constantly evolving and these recommendations are drafted as an input for Delaware's collaborative spirit and as a significant step toward paying for value.[iv]

The seven recommended strategies, in brief, are: [2]

1. Strategy I: Improve Health Care Quality and Cost: Implementing a statewide health care spending benchmark with a growth rate linked to the overall economy of the state creates a path to transforming Delaware's health care system to a more outcome-driven system and away from a system that pays for care based solely on the number of room days, visits, procedures and tests.
2. Strategy II: Pay for Value. There is consensus that the current volume-based payment systems contribute to health care cost growth, including overutilization and waste.
3. Strategy III: Support Patient-Centered, Coordinated Care. Patient-centered care recognizes that a person's health is determined by physical, psychological, and environmental factors, and offers approaches that empower patients while responding to "whole-person" care.
4. Strategy IV: Prepare and Support the Health Provider Workforce and Health Care Infrastructure Needs. There are significant provider shortages, particularly in primary care, dental, and mental health and substance abuse.
5. Strategy V: Improve Health for Special Populations. Targeted interventions focus resources on high-need populations and communities experiencing health disparities and social inequities.

[2] These strategies are taken nearly verbatim from the *Road to Value* report.

6. Strategy VI: Engage Communities. Recognizing that health is primarily determined by factors outside of the health care system, the state needs to increase opportunities for patients, caregivers and communities to make healthy choices through effective initiatives.
7. Strategy VII: Ensure Data-Driven Performance. To achieve better health care, lower costs, and healthier communities, it is important to set clear targets and monitor performance against them for both quality and cost targets.

Health Care Benchmark.

In December of 2017, Delaware's DHSS submitted its Report to the Delaware General Assembly on *Establishing a Health Care Benchmark*. The report also responds to the legislative requirement that the Secretary of Health and Social Services report on the progress toward implementing an all-payer system aimed at improving health outcomes and limiting health care costs in the State.[v] More specifically, the report presents five strategies for Delaware to pursue to reduce Delaware's cost growth and improve health outcomes, These strategies, which are informed by a robust stakeholder process and five "Benchmark Summits," will both build upon and leverage the accomplishments of SIM.

The five recommended strategies, in brief, are to:[3]

1. Establish state health care spending and quality benchmarks.
2. Analyze and report on variation in health care delivery and costs coupled with making useful data available to providers.
3. Create heightened provider accountability for managing health care cost growth and quality, while providing support for practice transformation, to accelerate delivery system reform with the Delaware. This recommendation will include leveraging the State's role as a major health care purchaser to implement aligned Medicaid and state employee total cost of care risk-based contracting utilizing alternative payment methodologies and delivery models that share risk and accountability with providers.
4. Increase the use of risk-based contracting and pair this with support to providers to ensure they can be successful under such models.
5. Focus upon improving the underlying social and economic issues affecting health outcomes by working with stakeholders to develop and implement a population health

[3] These strategies are based on the DHSS report to the Delaware General Assembly.

strategy (i.e. Healthy Neighborhoods) that builds upon prior work and existing resources.

Outlook for AY4.

HCC will continue to make payment reform a top priority in AY4, with on-going support from its vendors. HCC and its vendors are currently engaged with Delaware's providers: (1) to improve the collection of data from providers to establish a more accurate account of the rate of adoption of VBP models among Delaware's providers; and, (2) to increase the rate of adoption of VBP models among providers.

LEVERAGING REGULATORY AUTHORITY

DHSS and HCC, have leveraged purchasing power and regulatory authorities within DHSS and across other state agencies, and received support and guidance from the General Assembly. Purchasing strategies in Medicaid and the state employee group health insurance plan are more coordinated, and effort has been made to leverage the Qualified Health Plan standards for Delaware's ACA marketplace to support VBP. The HCC has used Delaware's certificate of need law (known as the Health Resources Board) to prioritize value oriented review criteria for new capital projects.

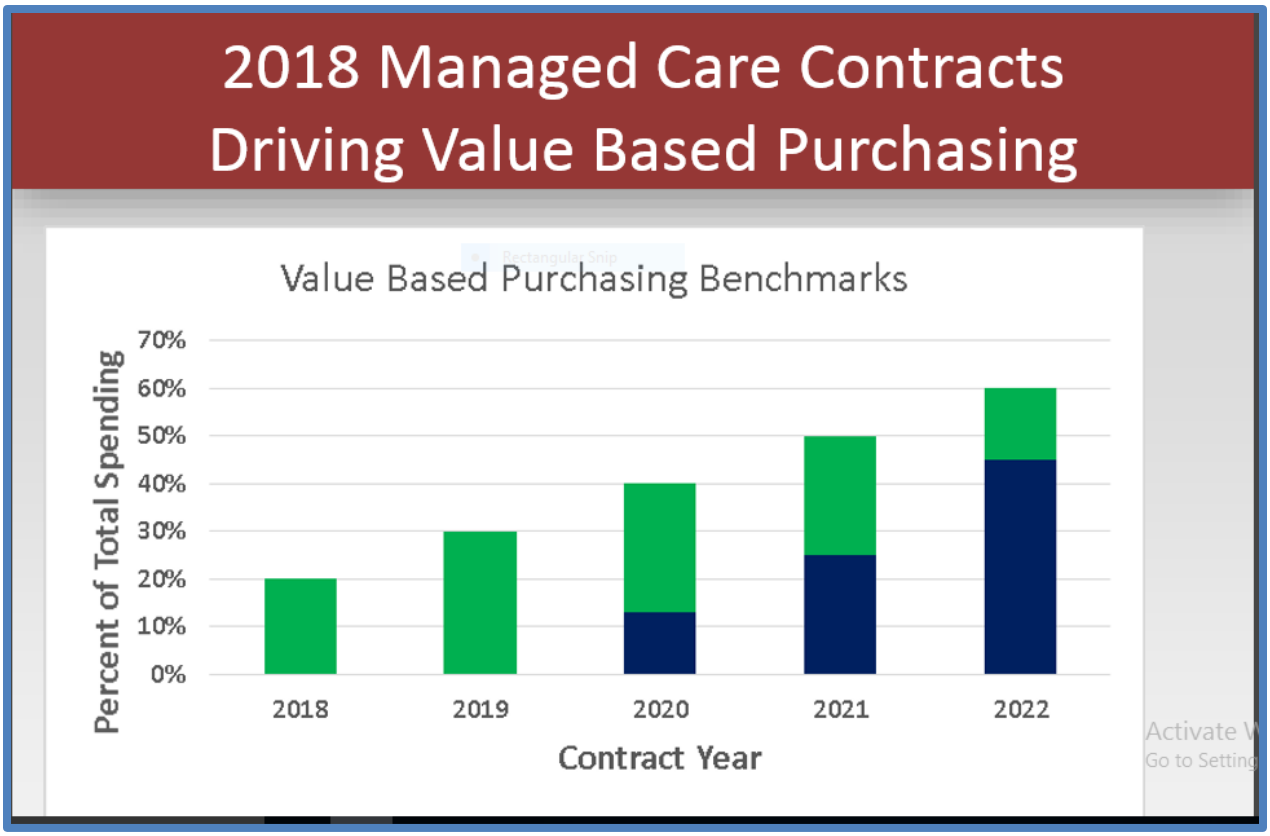
Change in Administration.

As previously covered, in AY3, Delaware's change in Administration sparked several other positive changes to drive payment reform: the *Road to Value*, followed by *Establishing a Health Care Benchmark.*

Medicaid Managed Care Organizations (MCOs).

Delaware's Medicaid program covers over 200,000 Delawareans, which makes Medicaid an important payer in advancing payment reform. The Department of Medicaid and Medical Assistance re-procured managed care contracts with two managed care organizations (MCOs), and announced new requirements for value-based payment in those new contracts effective January 2018. The two MCOs are required to establish VBPs arrangements with network providers over the term of the contract.

A recent presentation to the HCC by the Department of Medicaid and Medical Assistance (DMMA) highlights the Administration's emphasis on value-based purchasing arrangements.[vi]



Outlook for AY4.

The outlook for AY4 looks very promising, as another important payer, the Group Health Insurance Program for state employees pushes ahead to advance excellence. GHIP covers over 125,000 lives (approximately 15% of DE's population). In April of 2018, GHIP issued a bid for Centers of Excellence Administration for GHIP.[vii] Among the requirements listed in this Request for Response (RFR), entities must be able to demonstrate their ability to reduce total cost of care for GHIP participants and the State without sacrificing the quality of care provided to GHIP participants, and

The regulatory landscape looks stable for AY4, which ends in January 2019. That said, as HCC moves into the full swing of AY4 and the development of its Financial Sustainability Plan for CMMI, HCC anticipates that the components of this plan may require future legislative action, engagement and/or support from the General Assembly to map out the future for Delaware in the post-SIM era. Key decisions for the General Assembly may include re-organizing state health entities to better coordinate and oversee transformation efforts, and providing ongoing support for the health care spending benchmark process. After adjourning on June 30, the General Assembly will return to session in January 2019, or the end of AY4.

WORKFORCE AND EDUCATION

During AY3, as HCC's vision for implementation evolved, a clear and intentional decision was made to incorporate key goals to provide education and to strengthen the workforce into the work happening at the practice level. This dovetailed well with the addition of vendors including HMA with the clinical skill and expertise to provide coaching and training to the workforce. In short, the original SIM plan to focus on training and credentialing was replaced by a plan to leverage the opportunities to improve the workforce through the efforts to transform practices.

Outlook for AY4.

AY4 will continue to focus on supporting providers through practice transformation activities. The addition of the Behavioral Health Integration coaching will provide additional opportunity to improve workforce capacity.

HEALTH INFORMATION TECHNOLOGY (HIT)

Common Scorecard.

In AY3, HCC continued to support the Common Scorecard production of quarterly results that were made available to practices who logged in to a secure portal and saw their results on the measures relative to the results of other practices in the State. However, as the HCC consulted with DHIN and stakeholders, it became clear that there was not much engagement by practices with the measures. As a result, in AY4, the HCC is planning a change in focus on public reporting for state-level results, and creating a more sustainable, less costly approach to producing the Scorecard with DHIN. Moreover, the formal benchmark process will incorporate 2-5 quality metrics that will be tracked along with the year over year increase in per-capita spending, and the HCC is looking at the Common Scorecard metrics as possible candidate metrics. After the deliberations of Governor Carney's Advisory Committee on the Benchmark, Secretary Walker will make recommendations to the HCC and a sustainability plan will be developed for the quality metrics.

Health Care Claims Data Base.

In AY3, DHIN promulgated two rules necessary for the reporting of and access to data that will be housed in the HCCD. In addition, DHIN and HCC partnered to request Medicare data through RESDAC. Using SIM support, Freedman Healthcare assessed the level of resources needed to support ongoing operations of the Health Care Claims Database (HCCD). This assessment lays out the level of effort and resources required for DHIN across all tasks, without and with support from Freedman Healthcare.

Outlook for AY4.

In AY4. HCC will continue to reshape the HIT solution for Delaware, in partnership with its vendors and informed and shaped by what is feasible to accomplish in AY4. HIT is a critical aspect of transformation, which hit several challenges and delays in AY3, which have since been redefined as an opportunity to create a more efficient way to generate metrics for providers. The priority at DHIN will be testing and fully operationalizing the HCCD by the end of Year 4.

SUMMARY OF AY3 ACCOMPLISHMENTS

The following table summarizes the key accomplishments across all categories covered in the quarterly reports submitted to the Centers for Medicare and Medicaid Innovation (CMMI).[viii]

Key accomplishments for AY3 are summarized for two time-periods: (1) Time-period 1: AY3, Quarters 1-3 (Q1-Q3), which provides a synthesis of the accomplishment during first three quarters of AY3; and, (2) Time-period 2: AY3, Quarter 4 (Q4). The accomplishments for Q4 are separately highlighted to understand the promising outlook for AY4, which represents the final year of SIM implementation.

Summary of the Key Accomplishments and Milestones in AY3			
#	**CATEGORY**	**TIME-PERIOD 1: Q1-Q3: FEB 2017-OCT 2017**	**TIME-PERIOD 2: Q4: NOV 2017-JAN 2018**
A	INFRASTRUCTURE	Over this time-period, several changes were made to strengthen the infrastructure and foundation for implementation of the DE SIM. Important changes included: (1) leadership and staffing changes including the hiring and swearing in of a new Secretary of DHSS and hiring of a new Director of Health Care Reform within DHSS; and (2) the development of procurement opportunities to hire vendor(s) to provide project management, operational supports, and subject matter expertise (SME) to advance Healthy Neighborhoods and Behavioral Health Integration (BHI). During this time, state leaders maintained their focus on engaging stakeholders and on seeking clinical input.	During Q4, HCC continued to refine its operational infrastructure by streamlining stakeholder engagement, by reducing the number of active committees, and by creating a statewide consortium to stand up the Healthy Neighborhoods initiative. The new vendors began work in earnest. Mercer assumed a comprehensive approach to advance value-based payment models. HMA assumed a full workload of responsibilities to bring overall project management services, and to advance the direction of Healthy Neighborhood and Behavioral Health Integration initiatives.

Summary of the Key Accomplishments and Milestones in AY3			
#	**CATEGORY**	**TIME-PERIOD 1: Q1-Q3: FEB 2017-OCT 2017**	**TIME-PERIOD 2: Q4: NOV 2017-JAN 2018**
		At the end of Q3, a new ED was appointed to the HCC, and 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).	
B	**STAKEHOLDER ENGAGEMENT**	HCC remained focused on engaging stakeholders, while also keeping stakeholders informed about changes in infrastructure. Stakeholders demonstrated a high level of engagement through high turnout at the DCHI cross-committee meeting. In addition, the state-led evaluation team began its work on the evaluation and sent out a survey to 131 DE SIM stakeholders.	Stakeholder engagement remained strong, as stakeholders were engaged in the development of the Healthy Neighborhoods model; and, were asked to participate in the development of plans to advance value-based payment models.
C	**POPULATION HEALTH: HEALTHY NEIGHBORHOODS**	HCC commitment to Healthy Neighborhoods remained strong.	HMA presented a final model for the development and feasible implementation of Healthy Neighborhoods initiative, which included creating a streamlined process for standing up three Healthy Neighborhoods, creating an infrastructure and process for approving plans prepared by Local Councils, establishing a Statewide Consortium of providers to serve as the "sounding board" for locally-prepared plans, and identifying an internal "backbone" organization to distribute funds directly to community organizations. By year's end, one of the communities

Summary of the Key Accomplishments and Milestones in AY3			
#	**CATEGORY**	**TIME-PERIOD 1: Q1-Q3: FEB 2017-OCT 2017**	**TIME-PERIOD 2: Q4: NOV 2017-JAN 2018**
			proposed a plan, and is pending approval.
D	**HEALTH CARE DELIVERY: CLINICAL DELIVERY TRANSFORMATION**	HCC commitment to both major initiatives including Practice Transformation (PT) and Behavioral Health Integration (BHI) remained strong.	Key accomplishments ranged from: (1) steady improvement in practice performance as measured against practice transformation milestones, as demonstrated on the monthly practice reports (MPRTs); (2) launching of the of the Behavioral Health Initiative (BHI); and (3) release of the Request for Proposals (RP) for Electronic Medicaid Records (EMR) vendor.
E	**PAYMENT MODELS AND REFORM**	DHSS developed and released *Delaware's Road to Value, which is a paper* reflecting Governor Carney's goals and direction to transform the Delaware health care delivery system and improve health outcomes. In addition, HCC supported four Healthcare Spending Benchmark Summits and one Legislative Townhall to engage and receive input from national and local experts, as well as local stakeholders, and prepare for the next legislative phase of operationalizing a health care benchmark.	HCC continued to keep the focus on promotion and implementation of value-based payment reform. By the end of the year, 30 percent of all providers reported their participation in some form of value-based payment model. HCC continued the Healthcare Spending Benchmark Summit Series, which were well attended. DHSS submitted the Benchmark Report to the General Assembly, (December 2017). HCC held the "Payer and Purchaser Summit" (January 2018).

Summary of the Key Accomplishments and Milestones in AY3			
#	**CATEGORY**	**TIME-PERIOD 1: Q1-Q3: FEB 2017-OCT 2017**	**TIME-PERIOD 2: Q4: NOV 2017-JAN 2018**
F	**LEVERAGING REGULATORY AUTHORITY**	HCC created a new Third-Party Administrator (TPA).	HCC worked with Medicaid to identify opportunities to expand the use of measures included in the Common Scorecard to Medicaid Managed Care Organizations (MCOs), and to incorporate seven of the metrics included in the Common Scorecard into Medicaid MCO contracts. HCC issued a Request for Information (RFI) on shared risk to plans and providers to gauge their level of interest and willingness.
G	**WORKFORCE AND EDUCATION**	HCC made the decision to end certain components of the SIM program including the training and retraining program and the graduate education consortium.	HCC built workforce goals into the Practice Transformation initiative.
H	**HEALTH INFORMATION TECHNOLOGY (HIT)**	HCC asked for an assessment from Freedman Healthcare to determine resources necessary for on-going operations of Health Care Claims Data (HCCD). In addition, HCC continued to work on the development of the Common Scorecard.	HCC continued to make progress on several fronts, including: (1) the Common Scorecard; (2) development of regulation around data access; and, (3) an HIT focus on BHI.

Source: DHSS, based on accomplishments reported during AY3.

D. Summary of Challenges and Delays

Challenges and delays are part of all SIM initiatives, as they are ambitious, and require significant resolve and effort on the part of government, payers, providers, plans, and consumers. On top of such, state landscapes are not static; states are living, breathing environments that can lead to challenges, as well as new opportunities.

In AY3, Delaware faced several changes including: (1) a change in Administration; (2) a new HCC Director; and, (3) the onboarding of new vendors for the project management, Healthy Neighborhoods, Behavioral Health Integration, and Payment Reform to resolve the capacity constraints faced by DHIN. Overall, these changes, which created certain challenges for HCC in

meeting all milestones, paved the way for a smoother implementation of the SIM initiatives by the end of AY3.

AY3 goals were modified around the feasible and the possible, informed and shaped from an on-the-ground perspective by stakeholders. New vendors offered a set of new skills needed to refine the overall SIM plan and collapse the plan's eight drivers into four drivers, which greatly assisted in the state's overall ability to streamline activities, to launch Healthy Neighborhoods and the BHI pilots and engage stakeholders in a meaningful way.

E. Summary of Funding

Delaware's total budget in AY3 was $10,549,995. The total budget for AY3 represents the sum of two numbers: (1) the AY3 award of $5,604,505; and, (2) a carryover from AY2 of $4,940,158. The following table provides an account of the total amount expended to support AY3 DE SIM initiatives including those activities reflected in this annual report. The categories used to categorize spending across SIM activities. AY3 unspent funds in the amount of $6,278,318 have been requested as a carryover amount to AY4.

AY3 Spending by Project Area		
Line	**Project Area**	**Total Expended**
1	Overall Management/Establishing Infrastructure	$570,241.26
2	Patient & Consumer	$86,469.89
3	Population Health: Healthy Neighborhoods	$163,606.43
4	Health Care Delivery: Clinical Delivery Transformation	$1,697,010.89
5	Payment Models	$1,244,775.05
6	Workforce and Education	$157,200.47
7	Health Information Technology (HIT)	$382,879.25
	All Other	
	Travel	$7,419.35
	Other/Admin	
8	Total Expended	**$4,309,602.59**
9	Year 3 Award (includes Y2 Carryover)	**$10,544,663.02**

Source: DHSS, based on expenditures as of January 31, 2018.

F. Summary of State-Led Evaluation

Consistent with prior years, Concept Systems, Inc. (CSI) conducted the state-level evaluation of the state's SIM initiative (referred to as DE SIM).[ix] In collaboration with stakeholders, the state-led evaluation is expected to provide input on, track, and inform stakeholders of progress

towards unique, state-specific implementation milestones and model outcomes. In doing so, a feedback loop will be created for Delaware to track implementation, make mid-course corrections, and meet program goals. Throughout AY3, CSI engaged stakeholders in a continuous improvement approach to examine the processes and outcomes of DE SIM.

Please see the full report from the state-led evaluator in **Appendix A**.

G. Summary of Sustainability Strategies

In AY3, HCC pursued a multi-pronged approach towards sustainability: (1) to establish a strong organization; (2) to deliver on plans to implement population health and clinical transformation through Healthy Neighborhoods and BHI pilots; and, (3) to advance payment reform. These goals were achieved, while also noting that other goals including one to establish a strong HIT solution for Delaware would require additional attention in AY4.

As AY4 unfolds, HCC remains firmly committed to the sustainability of SIM initiatives, and looks forward to working with state policy leaders, payers, providers, practices and communities across the state to ensure the development of a sustainable plan that puts health outcomes, quality and cost in balance.

The establishment of the health care quality and cost benchmark will serve as a metric by which Delaware's overall transformation efforts are succeeding, and it will require a small but critical state investment to ensure its sustainability, as well as collaboration across state and private entities to share data and analytic capacity. New purchasing strategies have "taken hold" at both the Group Health Insurance Program (GHIP) and the Department of Medicaid and Medical Assistance (DMMA) Medicaid MCO contracting team. New waiver authorities or other regulatory levers will be explored as part of sustainability. New approaches to benefit design and member engagement of state employees enrolled in the GHIP are also under consideration.

H. Conclusion

The Delaware HCC is confident about the future sustainability of the SIM initiative, as it moves from AY3 into AY4, the final year for the DE SIM initiative. The infrastructure is becoming stronger. The implementation plan is solid. Vendors are on board and are in full swing. The Healthy Neighborhoods model is up and running; and, the BHI pilots are in gear. Linkages across drivers and activities are in development. Stakeholders remain committed. HCC is well positioned for a successful AY4. As AY4 proceeds, payment reform will continue to remain the highest priority for HHC.

End Notes

[i] Triple Aim Plus One. See: http://dhss.delaware.gov/dhss/dhcc/files/annualreport1.pdf

[ii] Key documents used to inform content included in this report: (1) the State Innovation Model Annual Progress Report, May 1, 2017 (for AY2); (2) the AY3 Operational Plan; (3) the AY3 Quarterly Progress Reports (QPRs); (5) the Report to the Delaware Assembly Benchmark; (6) the DRAFT Road to Value; (7) the Delaware Healthy Neighborhoods Model; (8) an assessment of the DHIN Resources Necessary for HCCD Operations by Freedman Healthcare; (9) the Monthly Progress Reporting Tool, which reports on vendor Practice Transformation (PT); and finally, the state-led evaluation of AY3, draft (version March 2018).

[iii] Learn more about LAN. Available at: http://hcp-lan.org/workproducts/apm-factsheet.pdf

[iv] DRAFT, Road to Value. September 2018. (This is the final version of the Road to Value.)
See: http://www.dhss.delaware.gov/dhss/roadmapmerged.pdf

[v] Delaware Health and Social Services. Secretary Dr. Kara Odom Walker. Report to the General Assembly of Delaware, December 15, 2017. As required by Section 192 of House Substitute 1 for House Bill 275, this report provides an update on progress towards implementing an all-payer total cost of care health care spending benchmark aimed at helping our State have the necessary information to make continued progress toward improving health outcomes and reducing unnecessary health care costs. The Secretary of the Department of Health and Social Services (Department) was required to submit to the Director of the Office of Management and Budget, the Controller General and the Co-Chairs of the Joint Finance Committee a report by December 1, 2017 detailing the feasibility of implementing a health care benchmark. The Department received an extension to December 15, 2017 to submit the report. This extension enabled the Department to incorporate comments received from both submitted comments (see Appendix D) and from in-person stakeholder meetings on the preliminary draft version of this report that was released earlier this month.

[vi] Presentation to HCC by Steve Groff, Medicaid Director.

[vii] See: http://www.delawarebids.com/bid_opportunities/2018/04/07/8546992-centers-of-excellence-administration-for-group-health-insurance-program.html

[viiiviii] For a detailed summary of the accomplishments by quarter, see the Quarterly Progress Reports (QPRs), prepared by HCC.

[ix] Concept Systems, Inc. (CSI) prepared the AY2 evaluation, which was available for the *State Innovation Model Annual Progress Report, May 1, 2017*. A draft of the AY3 evaluation prepared by CSI was available for this State Innovation Model Annual Progress Report for AY3.