



SIM Round 2 Model Design State Health System Innovation Plan Development Guidance

**Center for Medicare and Medicaid Innovation
State Innovation Group**

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Section I: Model Design Deliverables

A. Overview of the State Innovation Model

This document provides guidance for states to support a successful launch of the Model Design project.

- **Section I** provides an overview of the Model Design goals, further description of the State Health System Innovation Plan components, and the expected timeline of project deliverables.
- **Section II** provides step-by-step considerations for the organization and execution of the project, based on lessons learned from the Round 1 Model Design process.
- The **companion Excel workbook** provides samples of project plan tables, charts, and budget formats for organizing the project.

1. The State Innovation Models (SIM) Initiative

SIM is based on the premise that state-led innovation, supported by broad stakeholder input and engagement, will accelerate health care delivery system transformation to provide better health and better care at a lower cost. SIM encourages public and private sector collaboration to design and test multi-payer models to transform the health care systems in the state. SIM Model Design cooperative agreements provide financial and technical assistance to support states in developing a State Health System Innovation Plan (SHSIP or “Innovation Plan”).

2. The Model Design Goals

The goal of the Model Design award is to support states in using all of the levers available at the state level to engage stakeholders – including payers, providers and the public – to design a plan that can deliver significantly better care, smarter spending and healthier people through statewide transformation of the health care delivery system, payment methodologies, and integration of population health interventions. CMS has identified several characteristics to be closely associated with transformed health care delivery systems, including the movement of over 80% of payments to providers from all payers to fee-for-service alternatives that link payment to value. This goal is in line with the U.S. Department of Health and Human Services’ goal to tie 60% of all traditional Medicare FFS payments to alternative payment models and 90% of Medicare payments to quality or value by 2018¹.

States that are continuing work with a second Model Design award should build upon initial stakeholder engagement and planning work to create an Innovation Plan with additional specificity that meets the robust goals of transforming 80% of all payments made to providers and implementation of delivery system reform on a statewide basis.

¹ <http://www.hhs.gov/news/press/2015pres/01/20150126a.html>

A State Health System Innovation Plan will:

- Use assessments of the state population’s health to identify specific gaps between current status and goals, identify communities and populations that experience health disparities or account for a disproportionate percentage of health care costs, and identify current state and local efforts to advance population health and opportunities for improvement in each area (burden, disparities, cost-drivers, population health effort alignment). These findings should be used to develop a population health framework to inform the health system transformation efforts;
- Identify current health care delivery systems and payment methodologies in the state and opportunities for improvement in each area;
- Analyze levers available to the state for addressing the issues surfaced by information gathered from assessments and identified opportunities for improvement, whether through traditional functions such as public health, insurance regulation, employee benefits and Medicaid; or through other State departments and functions such as professional licensure/re-licensure standards, educational programs for health professionals, housing, labor, environment, agriculture, transportation, the prison system, etc.; and
- Bring together public and private health care stakeholders to develop a model for systematically transforming the delivery of health care and to devise statewide payment methods that improve the health of the entire state population.

B. Timeline

The period of performance for a Round 2 Model Design cooperative agreement award is 12 months. Awardees are required to collaborate in periodic communication with SIM staff and to submit quarterly progress reports during the award period as they develop an Innovation Plan. The quarterly reports should contain status updates on the development of Innovation Plan components, along with drafts of the components.

The following table provides a timeline of interim deliverables and a recommended timeline of providing drafts of the Innovation Plan components along with the progress reports. The submission of draft components ensures progress is being made towards the ultimate deliverable, and also ensures that CMMI may deliver customized technical assistance throughout the project period. All deliverables must be submitted via email to the CMMI Project Officer.

Deliverable	Deadline*	Recommended component for draft submission
Updated Operational Plan	February 28, 2015	<ul style="list-style-type: none"> • See FOA p. 31
Stakeholder Engagement Plan	March 30, 2015	<ul style="list-style-type: none"> • Please review p. 6 of Model Design Guidance, below, for further details

Q1 Quarterly Progress Report	May 30, 2015	<ul style="list-style-type: none"> Quarterly Progress Report Population Health Plan (Draft) Driver Diagram (Draft)
Q2 Quarterly Progress Report	August 30, 2015	<ul style="list-style-type: none"> Quarterly Progress Report Draft Value-based Health Care Delivery and Payment Methodology Transformation Plan (Draft)
Q3 Quarterly Progress Report	November 30, 2015	<ul style="list-style-type: none"> Quarterly Progress Report Health Information Technology Plan (Draft) Operational & Sustainability Plan (Draft)
Full Draft: State Health System Innovation Plan	December 30, 2015 (Optional)	<ul style="list-style-type: none"> The first full draft should include all updates to previous draft submissions.
Final State Health System Innovation Plan	January 31, 2016	<ul style="list-style-type: none"> The final draft should include all updates to previous draft submissions.
Final Progress Report	April 30, 2016	

* Dates based on a project period start date of February 1, 2015.

C. Project Milestones and Deliverables

1. Operational Plan

All Model Design awardees must submit an Operational Plan update within 30 days of the start of the project period. The updated Operational Plan should provide a proposed project timeline with milestones, including dates by which the awardee will submit drafts of each component.

States that are building on prior design work may want to follow a somewhat different order of activities in recognition of work already completed. If a different order or different activities are needed to support the state's process for developing the Innovation Plan, modifications should be discussed with the CMMI Project Officer (PO) to secure approval, and to seek prior approval for any needed budget changes. The Operational Plan should reflect the activities and the amount of time and dependencies of various activities in order to complete a robust Innovation Plan.

Some states may find the companion Excel workbook with samples of project plan tables, charts, and budget formats, as a helpful template to use in developing the Operational Plan and organizing the Model Design project. Each tab in the workbook contains the format for a project plan element discussed in this guidance document.

CMMI expects that work on all milestone and draft submissions discussed below will be initiated within the first six months of the SIM award. A narrative description of progress toward each milestone will be submitted in the Quarterly Progress Reports (QPR).

2. Stakeholder Engagement Plan

Within 60 days, each awardee must submit a plan for engaging stakeholders to the PO. A plan for engaging stakeholders should achieve the following:

- 1) Demonstrate that sufficient diversity of geographic, clinical, payer and state/community services are involved by providing a list of stakeholders, and the organizations they represent, that will participate in the development of the plan. Stakeholders from throughout the state should be represented in at least the following areas:
 - a. State Government Agencies (e.g. Governor's office, health, insurance, social services, mental health & substance abuse, developmental disabilities, office on aging, education, transportation, housing, tribal affairs, parks & recreation, labor and other relevant offices)
 - b. Regional and local government organizations (e.g. local public health departments, tribal representatives, patient advocacy groups, as applicable)
 - c. Providers (hospitals, physicians, long term care organizations, ancillaries)
 - d. Payers (commercial insurance companies, self-funded employers, Medicaid)
 - e. Community organizations
 - f. Patient advocacy organizations
- 2) Describe how stakeholders will be engaged and kept engaged;
- 3) Describe what role stakeholders will play in the Innovation Plan development (e.g. workgroup member, subject expert);
- 4) Show that representatives with appropriate subject matter expertise and practical experience are participating (e.g. clinicians are engaged in delivery system transformation work group);
- 5) Provide evidence that the purpose of each stakeholder activity is communicated to those involved;
- 6) Demonstrate that the method of engagement provides sufficient time and process for meaningful input;
- 7) Explain how stakeholder input will be developed into usable information to shape decisions; and
- 8) An initial timeline for stakeholder engagement activities.

Towards the end of the Innovation Plan development many of the stakeholders will have worked on only part of the process to assess options and shape decisions. In order to gain broad support, states may need to hold stakeholder meetings and present the plan as a whole and explain the rationale for the full set of decisions that are included in it. Allowing for questions and discussion by stakeholders can help secure buy-in. For instance, it will be important for providers to understand how their current work

and financial relationships may change. Will the staffing in their office need to change? Will they need to develop different referral relationships? What information will they have to collect and analyze? What factors will influence how much they are paid? How many patients will they serve and how will those patients find them? Including time for these discussions in your plan will be important.

3. Quarterly Progress Reports

As specified in the Program Terms & Conditions, Quarterly Progress Reports (QPRs) are due 30 days after the end of each quarter of the Model Design award performance period. The quarterly report must include the status of the project activities and a narrative summary of the period's accomplishments and any barriers to reaching them. As mentioned above, milestone and draft submissions should accompany the progress reports.

Assuming a February 1, 2015, start for the award, the QPRs will be due:

1. May 30, 2015
2. August 30, 2015
3. November 30, 2015
4. January 31, 2016

4. Driver Diagram

With the first QPR, CMMI recommends that each state submit a draft driver diagram. The driver diagram should identify:

1. The major **Aim(s)** of the health system transformation
2. The **Primary Drivers** for achieving the aim
3. The **Secondary Drivers** for achieving the aim

Driver diagrams are a tool for defining transformation aims and key factors (drivers) that are essential to achieving those aims. They are similar to logic diagrams, which some professions use to identify short- and long-term outcomes, target groups to reach, and the activities needed to reach the target groups. Additional information about driver diagram development is provided in a section below as well as in Appendix B of this document.

5. Population Health Plan

With the first QPR, CMMI recommends each state provides an initial assessment of gaps in access to care and health status disparities to be addressed in the delivery system transformation. By the second QPR, states should provide draft strategies for addressing high priority areas and gaps.

6. Value-based Health Care Delivery and Payment Methodology Transformation Plan

With the second QPR, CMMI recommends that each state submit its draft plan for transforming the health care delivery system and reimbursement methodologies from fee-for-service to value-based

alternatives. This plan should address how commercial as well as Medicaid payers will support providers in providing better care and improving the health of the population while reducing costs.

By the third QPR, CMMI recommends including information on the proposed delivery system transformation model including the measures that will be used in future implementation to assess improvements in both the health of the state population and quality of care delivered as a result of the transformation efforts.

7. Health Information Technology Plan

With the third QPR, CMMI recommends that each state submit a plan for how the expansion of health IT adoption and health information exchange infrastructure will be developed to provide the data and analytical capability to support provider practices and other relevant organizations with improving coordination and delivery of care, exchanging clinical information on a real time basis and improving the health of the population.

8. Final Deliverable: State Health System Innovation Plan

Each Model Design awardee is required to deliver by the project period end date a written State Health System Innovation Plan document to serve as a final deliverable for the Model Design award. The state may submit a draft of the Innovation Plan prior to the end of the project in order to receive technical assistance from CMMI and contractors. The plan should include the state's vision for a transformed health care delivery system and describe state authority that will be employed, including any federal waiver(s) or state plan amendment(s) required, to implement the plan and enable key strategies for transformation. The plan should also explain how it incorporates broad provider and multi-payer commitment to achieving statewide health care delivery transformation. Finally, the plan should address how the plan can be operationalized and sustained without depending on additional federal SIM funds. Additional information is provided in the FOA and the section below.

The State Health System Innovation Plan must include sections on each of the following topics specified in the FOA:

- a. Description of State Health Care Environment
- b. Report on Stakeholder Engagement and Design Process Deliberations
- c. Health System Design and Performance Objectives
- d. Value-Based Payment and/or Service Delivery Model
- e. Plan for Health Care Delivery System Transformation
- f. Plan for Improving Population Health

- g. Health Information Technology Plan
- h. Workforce Development Strategy
- i. Financial Analysis
- j. Monitoring and Evaluation Plan
- k. Operational Plan

A best practice would be to incorporate, for each component:

1. The state's strategy to advance the health of the entire population as part of the health care transformation efforts;
2. A description of the state regulatory and policy levers available and any federal waiver or state plan amendment requirements and their timing to enable key strategies for transformation;
3. The associated driver diagram defining the state aims, primary and secondary drivers;
4. A health care delivery system transformation model(s) and value-based payment methodology;
5. Quality and performance measures to be developed or adopted and monitored in the model;
6. A description of how the plan aligns with other federal, state, regional and local innovation models; and
7. How the transformation will be organizationally and financially sustained.

The determination made early in the project planning process regarding how decisions will be made will guide the final development of the State Health System Innovation Plan. At this point, the multiple points of view will need to be coalesced into a single document with a recommended health system delivery model, a reimbursement methodology to support it, and supporting strategies and infrastructure are defined. The process will need to address the extent to which stakeholders will be given a say in the final shape of the plan. How will disagreements be addressed? Who will make final decisions and who will authorize the final plan document?

Most states have processes for making important policy decisions such as these. As the decisions are made, the final document can be prepared for submission.

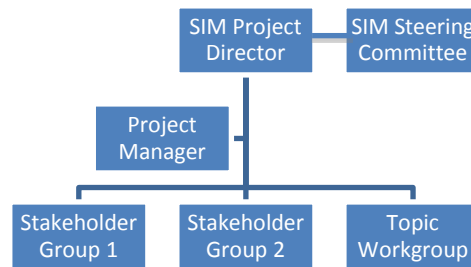
Section II: Establishing the SIM Model Design Project

These following guidance and templates are provided as optional tools and resources for Model Design awardees. Awardees may utilize whichever tool they prefer as long as there is a method to establish and track accountability, effectively manage the awarded budget, and successfully complete all Model Design award requirements.

A. Organization

1. Staffing

The SIM Model Design project will involve a large number of people from across many organizations, not all of which are affiliated with the state. At the beginning of the project, the state should identify all project participants, whether they are state employees, consultant/contractors, or representatives from stakeholder organizations or community groups. In developing a project plan, the awardee may begin by defining the key activities and aligning the type of expertise needed to accomplish the activity. The awardee may also take into consideration the staff available from the lead agency, other sister agencies within the state, as well as contractors and stakeholders. Model Design awardees should develop an organizational chart for the project that reflects how the various members will relate to each other, such as the example below:



Model Design teams should define and implement communication protocols to ensure that all relevant entities will receive pertinent information. The use of meeting agendas, meeting decisions is recommended.

2. Identifying Decision Makers and Defining the Process for Making Decisions

Once key team members and the governance structure for the SIM project have been defined, a method for decision making should be developed and confirmed.

B. Developing the SIM Design Project Plan

1. Assign Roles and Responsibilities

Once the key project leaders are identified, an accountability matrix is a helpful tool to track which person will be accountable for making sure that each of the major activities is accomplished. An example of an accountability matrix is included below:

SIM Project Activity Accountability Matrix						
Number	Activity	Lead Accountable Position	First name	Last Name	Contact Information	
					email:	Phone
1	Planning Phase	SIM Project Director				
1.1	Develop Project Plan	Executive Sponsor & SIM Project Director				
1.2	Establish Communication and Operating Protocols with CMMI, State staff and Stakeholders	SIM Project Director				
1.3	Define Org Structure, Staffing and Budget	Executive Sponsor & SIM Project Director				
2	Identify State Levers to Transform Healthcare	SIM Project Manager and State Executive Steering Committee				
3	Identify Population Health Gaps	Director of Public Health				
4	Engage Stakeholders	SIM Project Director & Medical Officer				
5	Develop Driver Diagram	SIM Project Director				
6	Decide Delivery System Transformation Model(s)	Executive Steering Committee & Stakeholders				
7	Define Value-based Payment Methods to Support Delivery Model(s)	Executive Steering Committee & Stakeholders				
8	Define Health Quality /Performance Measures	Director of Health Care Quality				
9	Define Health Information Technology Needed for Model	Director of HIT				
10	Define Healthcare Staffing / Workforce Model	Medical Director				
11	Write Draft of SHSIP	SIM Project Director				
12	Gain consensus/approval for SHSIP	SIM Project Director				
	Submit final SHSIP	SIM Project Director & Executive Sponsor				

Model Design project leads may use this information to develop a project management tool, such as a Gantt chart, that tracks the start point and duration of each activity and its dependencies on prior activities, if applicable. The due dates for key milestones should also be completed on the chart. The major activities should match the accountability chart above. An example of a Gantt chart is provided below and a template is available in the companion Excel workbook.

2. Example of a Gantt chart

SIM Design Model Project Gantt Chart			Q1			Q2			Q3			Q3			Due
Number	Activity	Lead Accountable Position	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Date
1	Planning Phase	SIM Project Director													
1.1	Develop Project Plan	SIM Project Director													
1.2	Establish Communication and Operating Protocols with CMMI, State staff and Stakeholders	SIM Project Director													
1.3	Define Org Structure, Staffing and Budget	Executive Sponsor & SIM Project Director													
2	Identify State Levers to Transform Healthcare	SIM Project Manager and State Executive													
3	Identify Population Health Gaps	Director of Public Health													
4	Engage Stakeholders	SIM Project Director & Medical Officer													
5	Develop Driver Diagram	SIM Project Director													
6	Decide Delivery System Transformation Model(s)	Executive Steering Committee & Stakeholders													
7	Define Value-based Payment Methods to Support Delivery Model(s)	Executive Steering Committee & Stakeholders													
8	Define Health Quality /Performance Measures	Director of Health Care Quality													
9	Define Health Information Technology Needed for Model	Director of HIT													
10	Define Healthcare Staffing / Workforce Model	Medical Director													
11	Write Draft of SHSIP	SIM Project Director													
12	Gain consensus/approval for SHSIP	SIM Project Director													
	Submit final SHSIP	SIM Project Director & Executive Sponsor													

3. Tracking the Budget

Once the major tasks and timing of those tasks have been defined, the budget should relate to the major activities that will be undertaken. A best practice is to define the budget by both program activities and by quarter. A programmatic view of the budget is built upon the major activities developed in the responsibility matrix and carried through the project management tool (or Gantt chart). Below is an example of a programmatic view of a SIM Model Design budget using the previously -defined major activities, as well as a chart showing the OMB Object Class Categories from the SF 424. These budget formats are also available in the companion Excel workbook.

As a reminder, any changes to budget reflected in the SF 424 must be submitted for prior approval to the CMS PO and Grants Management Officer via grantsolutions.gov. Awardees should allow at least 30 days for review by CMS for any prior approval requests.

SIM Design Model Project Programmatic Budget						
	Activity	Budget	Q1	Q2	Q3	Q4
1	Planning Phase	\$\$				
1.1	Develop Project Plan					
1.2	Establish Communication and Operating Protocols with CMMI, State staff and Stakeholders					
1.3	Define Org Structure, Staffing and Budget					
2	Identify State Levers to Transform Healthcare	\$\$				
3	Identify Population Health Gaps	\$\$				
4	Engage Stakeholders	\$\$				
5	Develop Driver Diagram	\$\$				
6	Decide Delivery System Transformation Model(s)	\$\$				
7	Define Value-based Payment Methods to Support Delivery	\$\$				
8	Define Health Quality /Performance Measures	\$\$				
9	Define Health Information Technology Needed for Model	\$\$				
10	Define Healthcare Staffing / Workforce Model	\$\$				
11	Write Draft of SHSIP	\$\$				
12	Gain consensus/approval for SHSIP	\$\$				
	Submit final SHSIP	\$\$				
	Total	\$\$				

A view of the SIM project budget by OMB object categories would look like this:

SF 424 Budget Categories						
6	Object Class Categories	Budget	Q1	Q2	Q3	Q4
	a. Personnel					
	B. Fringe Benefits					
	c. Travel					
	d. Equipemenbt					
	e. Supplies					
	f. Contractors					
	g. Construction					
	h. Other					
	i. Total Direct Charges (sum of 6a-6h)					
	j. Indirect Charges					
	TOTALS					

4. Quality & Performance Measures for Delivery System Transformation

Each state's transformation effort should include a systematic way to monitor and track state progress towards quality improvement goals for the entire population, and all providers and payers.

Development and use of quality measures is critical for ensuring that changes maintain or improve the quality of care and patient experience. Cost and quality measure alignment across payers is also a critical factor for establishing multi-payer models that are measurable. It is recommended that states consider measures for each of the three parts of the triple aim: 1) the health of the population as a whole, 2) the quality of care provided to individual patient panels, and 3) the cost of care. Table 16 and Table 17 of the [Colorado R1 State Health Innovation Plan](#) provide an example of baseline data for the cost of care. A best practice would be for awardees, by the end of the SIM project, to have gathered baseline data for metrics, against which future progress can be measured.

During the 12 month performance period, Model Design awardees should also develop meaningful metrics related to the progress of their transformation plan. Awardees should also develop measures related to achieving better health, better care and more cost-effective care for future use in measuring the impact of their proposed innovations. States should use these measures during future implementation of their proposed delivery system transformation efforts in order to measure progress towards achieving the aims, and to maintain accountability. The SIM Model Test states utilize a set of "SIM Core Metrics" to measure the intended "spread" of models among the payer and provider community. The SIM Core Metrics approach will be described in training webinars during the year.

C. Active Transformation Design Development

With the project plan in place, awardees should begin actively working to define their approach to transforming health care delivery and creating a value-based payment methodology to support the health delivery system.

1. Readiness Assessment

An initial self-assessment may help to identify areas of project management strength and areas that may need additional definition prior to commencing active plan development. While the second round of SIM Model Design requirements vary in some ways from those of Round 1 Model Design awards, CMMI encourages Round 2 awardees to review completed Innovation Plans, as this may help to assess the areas where the state's SIM team is strongest, and areas where additional technical assistance may be helpful. A list of the publicly available Round 1 SIM Model Design Innovation Plans is contained in Appendix C of this document. Information on available technical assistance is provided below and in Appendix A of this document.

3. Identifying State Levers for Health Care Transformation

At the core, SIM tests the ability of state governments to achieve health transformation through use of available regulatory and policy levers. CMS believes that state governments, with the leadership of

governors and senior state leaders, can serve as critical partners to the federal government in transforming health care. Secondly, CMS believes states are laboratories of innovation due to the authorities available: States serve as a payer for a significant percentage of health care services for their residents, have broad regulatory authority over health care providers and payers, have the ability to convene multiple parties to improve statewide health delivery systems, and oversee public health, social, and educational services.

It is critical at the start of the SIM Model Design project period to inventory the levers available in the state to help drive this change. The state should conduct a thorough analysis to identify and assess the state policy and regulatory levers available to accelerate the transformation of health care. Examples of available regulatory and policy levers include:

- Public health departments (state, county, or local)
- Insurance Commission and health insurance regulations
- Employee benefits for public employees
- Medicaid and the Children's Health Insurance Program
- Insurance Marketplaces and regulation of Qualified Health Plans
- Certificate of Need regulations
- Professional licensure / re-licensure standards
- Hospital, SNF and other institutional quality regulations
- Price and quality transparency initiatives
- State antitrust laws and medical malpractice laws
- Educational programs for health and allied professionals
- Housing, transportation, labor, environment, agriculture and education departments are examples of state departments that may influence health status.
- The prison health system
- The Legislature and its committees that impact health

4. Identifying the Baseline Population Health Status

All SIM cooperative agreement awardees, as a condition of their funding, must develop a plan to improve the health and wellbeing of the state population within the context of the health system delivery and payment transformation plan.

The plan for improving population health should:

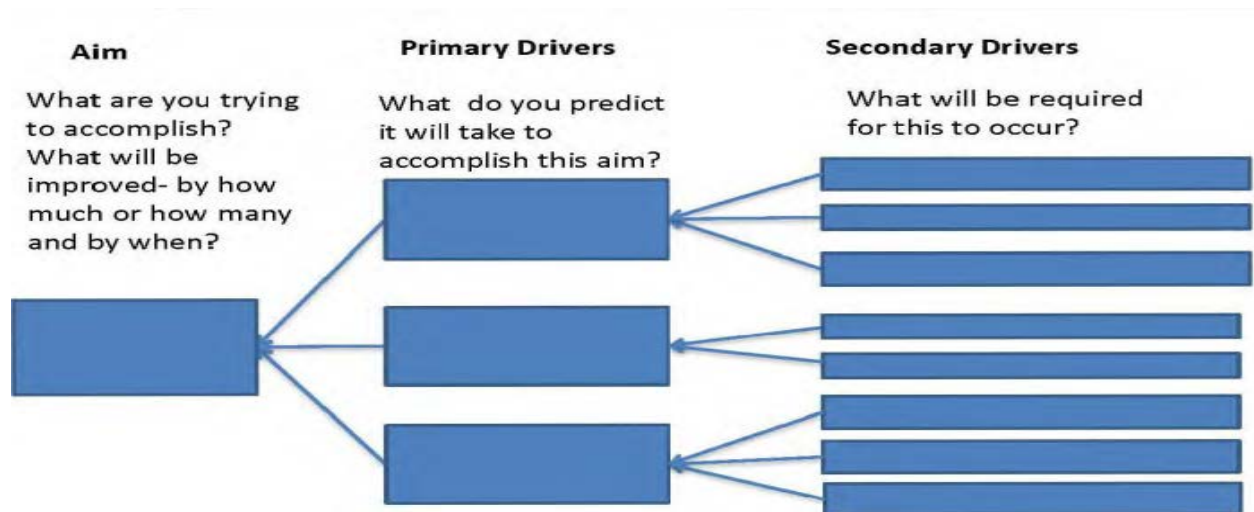
1. Identify gaps in access and disparities in the health status of state residents.
2. Leverage and build upon interventions and strategies included in an existing public health State Health Improvement Plan;
3. Create an inventory of the current efforts to advance the health of the entire state population, including efforts to integrate public health and health care delivery;

4. Leverage existing health care transformation efforts to advance population health;
5. Include a data-driven implementation plan that identifies measurable goals, objectives and interventions that will enable the state to improve the health of the entire state population.

Technical Assistance is available from SIM federal partners in the CDC for issues related to development of the plan for improving population health. The final plan will be incorporated as a section of the State Health System Innovation Plan.

5. Developing a Driver Diagram

The results of a population health assessment can inform the driver diagram process to identify the key aim of the SIM transformation as well as the primary and secondary drivers. An example of a driver diagram skeleton is provided here:



Additional information about Driver Diagrams, including a link to a CMMI tutorial on how to develop a Driver Diagram is found in Appendix B and at this link: [CMMI Driver Diagram Guide](#). Technical Assistance from the SIM program on Driver Diagrams is also available.

6. Document the Baseline Health Care Landscape

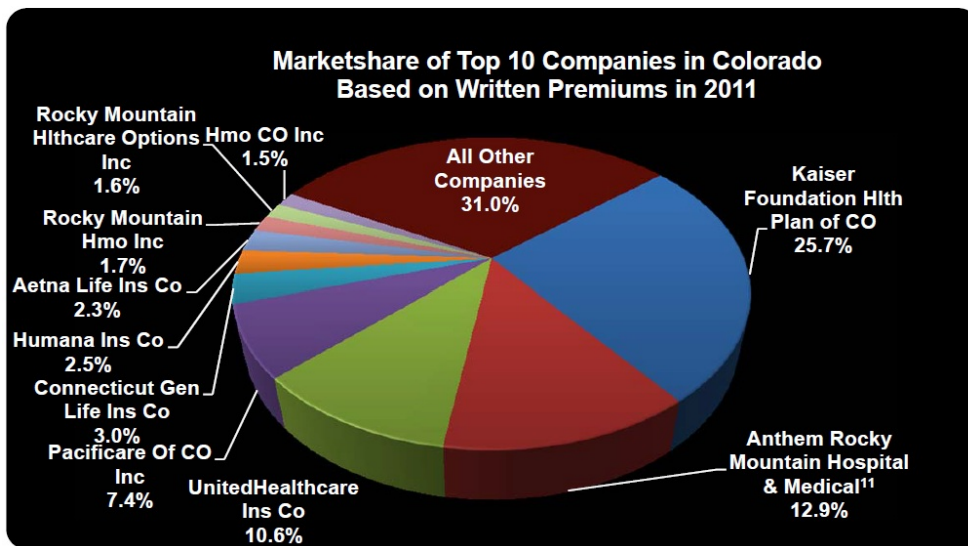
Knowledge of the state's current health care delivery and payment environment will inform the goals for the overall health care delivery and financing transformation and serve as an input to the Driver Diagram and the selection of a state health care transformation model.

1. Identify the current number of health care provider organizations in the State using the categories defined in Appendix D.
2. Identify the payers in the state with more than 5% of the market share with the number of members/beneficiaries that they cover:

- a. BlueCross/Blue Shield plans
- b. Other commercial plans
- c. Employer self-funded ERISA plans
- d. Medicaid
- e. Medicare
 - i. Model Design awardees will have three options for accessing Medicare data:
 1. The Public Use Files (PUF) and dashboards at no cost (data is limited);
 2. A Limited Data Set (LDS) request, which will require CMS review and approval, at no cost; or
 3. Apply for access to Medicare Research Identifiable Files via a state agency Data Use Agreement (DUA) request and pay the charges that apply. Visit www.RESDAC.org for assistance.

Additional information and technical assistance will be available from the SIM program on Medicare data access.

Below is an example of a summary of the payer landscape included in the Colorado State Health Innovation Plan:



For other examples of health care delivery system landscapes included in State Health Care Innovation Plans produced by SIM Round 1 Model Design states, see:

- Appendix A of [Washington R1 State Health Innovation Plan](#)
- Chapter 2 of [NY R1 State Health Innovation Plan](#)

7. Engaging Stakeholders

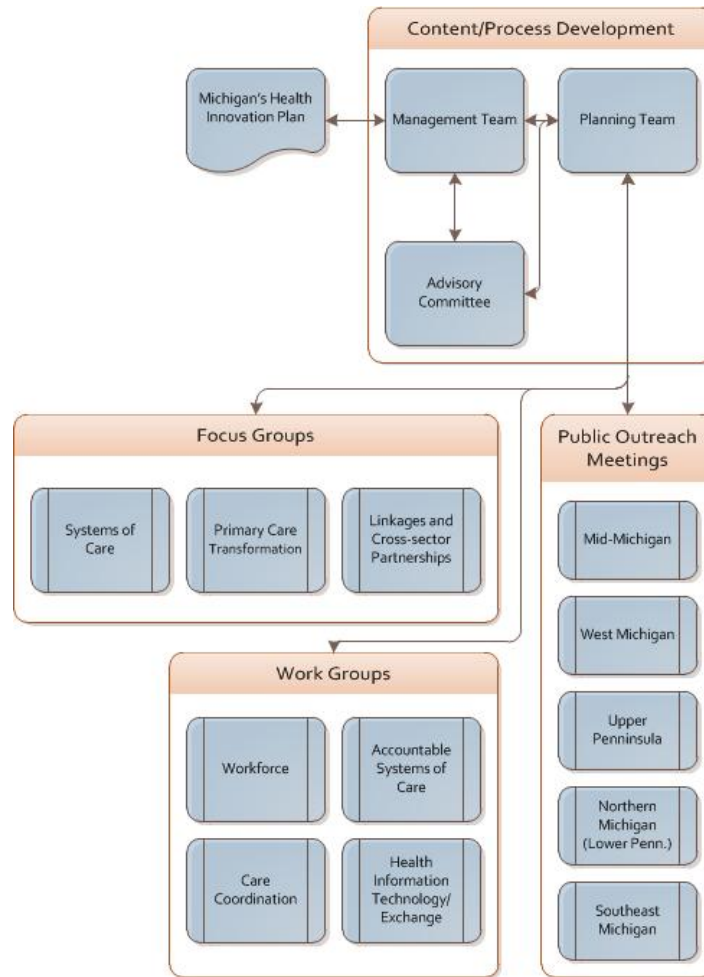
One of the most important, and most complex, aspects of a SIM Design project is engaging a wide array of stakeholders in state and local government agencies, social support agencies, health care provider organizations, health insurance/payer organizations and consumer and community advocacy groups. The following topics are designed to assist in planning the stakeholder engagement process.

It is critical that the state conduct a thorough analysis to identify the stakeholders who have knowledge, expertise, experience and roles in the payment and delivery of health care reform or in maintaining the health of the community, including:

- Payers – major commercial payers, Medicaid, Veteran’s Administration, Employers who self-fund employee benefits via ERISA plans.
- Providers – including organized delivery systems, academic medical centers, community hospitals, physicians (primary care and specialists), behavioral health providers, ambulatory diagnostic and treatment centers (surgi-centers, urgent care, etc.), long-term care providers, home health, hospice, community health workers and clinical social workers.

As previously mentioned, it is important for the State to engage a wide range of governmental stakeholders and community/patient stakeholders; examples of stakeholder groups are referenced in the Stakeholder Engagement Plan section above as well as the SIM Funding Opportunity Announcement.

It is recommended that records of the agendas of stakeholder meetings, as well as minutes are kept that clearly indicate follow up items. As a best practice, awardees may make meeting notes from large stakeholder meetings available on a public-facing website. Further, the state should identify formal mechanisms (e.g. health care transformation workgroups, stakeholder meetings, public comment processes) for communication, input, and shared decision making. For example, previous Model Design projects have particularly benefitted from stakeholder workgroups defined by individual topic, task, or by geography. The following diagram shows how Michigan coordinated the informational flow between multiple stakeholder groups and the SIM project management and steering teams.



D. Developing Health Care Delivery and Payment Transformation Models

This section will define key steps in creating model(s) for transforming care delivery and defining a payment methodology that rewards value -- quality and cost effectiveness -- to support the care delivery model.

1. Selecting care delivery transformation models

Define the range of models, their goals, impacts and advantages/disadvantages

There are a range of models for delivering care that improve upon today's fragmented and uncoordinated care delivery system. Technical assistance is available to assist States with understanding payment models such as accountable care organizations, shared savings based on total cost of care, episodes of care, advanced primary care initiatives and health homes, etc.

Define one or more health care delivery model(s)

State health policy experts, stakeholders in public health, and private provider communities, private insurers, employers, and state Medicaid staff will be among those integral to defining the model(s) of

care delivery that will best improve the health of the population in the state. Beginning with the needs identified in the plan for improving population health, consider how well the various transformation models identified will address the current needs. Stakeholders should identify activities for the proposed health care transformation models that leverage and complement existing initiatives aimed at advancing the health of the entire population, improving care and reducing cost. More than one model may be appropriate, as some models are complementary and some may work better in some regions or markets in the state than others.

Define the range and number of health care professionals and organizations involved

Another important part of creating a plan for statewide transformation of health care delivery is to understand which of the health care professionals in the state would – and should – be impacted by the plan. Potentially participating health care providers should be defined by geography and by type of provider (i.e. specialty, level of training such as MDs, NPs, PAs, psychologists, LCSWs, CHWs, etc.).

Define the range of social determinants of health

Health status is heavily influenced by factors beyond the health care delivery system, such as poverty, quality of housing, education, employment, “walkable” neighborhoods, and other factors. The range of sectors involved in the plan for transformation that extend beyond the traditional health care delivery sector should be defined.

2. Identify a value-based payment methodology to support the delivery model

The conventional health services payment structure reimburses providers for illness care more than preventive care, and generates fees based on the number of physician services provided (fee-for-service) rather than the quality or efficiency of care provided. As part of transforming health care delivery, the Innovation Plan should aim to move over 80% of payments to providers from all payers from fee-for-service alternatives that link payment to value, the intersection of quality and cost effectiveness.

It will be essential to engage both payers and providers in this planning process. A payment methodology has to be acceptable to the major payers in the state (insurance companies, self-funded ERISA employer health plans, Medicaid and others) while also being acceptable to the providers in order to succeed and be sustainable.

Define the number of providers and beneficiaries impacted

Once one or more value-based payment methodologies have been identified, intended scale and impact of the model should be defined. To document these impacts, the following groups should be identified: employers or payers who will participate, the providers who will receive each type of reimbursement, and the patients or beneficiaries whom they serve. The State Innovation Model Test states utilize a set of “SIM Core Metrics” to measure the intended “spread” of models among the payer and provider community. The Core Metrics will be the subject of a webinar during the year.

3. Defining the infrastructure needed to support the transformation and model

Both changing the care delivery model and the payment methodology are likely to require additional infrastructure support. Common types of infrastructure supports needed to accomplish these changes are health information technology, enhanced data analytics and reporting, and workforce training.

HIT/HIE needs

Awardees may utilize SIM Model Design funds to plan for the implementation of specific technology, software, applications, or other analytical tools as part of state infrastructure development. The state must provide a clear strategy for how the technological approach will be financed. Awardees should document the current state of health information technology adoption and utilization in the state, including current EHR adoption levels, percentage of providers meeting Meaningful Use requirements in the EHR Incentive Programs, and use of technology to support HIE activities. Awardees should provide detailed descriptions for health information technology plans in the following domains:

1. Rationale: How the specified HIT elements and/or programs, in combination, will achieve state-wide health transformation
2. Governance: Describe how state leadership will direct the planning and oversight during future implementation; supply a comprehensive plan for future implementation of infrastructure that leverages existing assets and aligns with federally-funded programs and state enterprise IT systems; and explain how the governance structure will incorporate and expand existing public/private health information exchanges, including those operated by ACOs.
3. Policy: Describe policy and regulatory levers that will be used to accelerate standards based health information technology adoption to improve care; describe methods to improve transparency and encourage innovative uses of data; offer a plan for promotion of patient engagement and shared-decision making; and propose multi-payer strategies to enable and expand the use of health information technology.
4. Infrastructure: Describe how the state will implement analytical tools and use data driven evidence based approach to coordinate and improve care across the state; offer plans to utilize telehealth and perform remote patient monitoring to increase access to care and the timeliness of care; articulate plans to use standards based health IT to enable electronic quality reporting; explain how public health IT systems (such as clinical registry systems) will be integrated; and describe how support of electronic data will drive quality improvement at the point of care.
5. Technical Assistance: Define how the state will provide technical assistance to providers; identify targeted provider groups that will receive assistance and what services will be delivered; and identify how the state intends to extend resources to providers ineligible for Meaningful Use incentive payments, if applicable.

This list is not intended to be exhaustive. States may propose alternative approaches to data analytics and health information technology that support delivery system transformation. States will be offered

the opportunity to obtain technical support from the Office of the National Coordinator for Health IT (ONC) in developing the plans.

Workforce and Training Needs

Changes in the process of delivering care can require training at many levels. Nursing staff may need additional training for care coordination with chronically ill patients. Physicians who have been trained to think and act autonomously may need training for team work and shared decision making. New types of care team members, such as community health workers, may require adaptation to state education and training requirements, in addition to certification at the state level for augmenting preventive, primary and behavioral health care. Staff in acute care settings and those working in long-term care or community settings may need to learn new communication protocols to best serve patients.

The state should consider data collection to address current supply and modeling methods that allow for projections of future demand for health workforce, and specify actions that will be taken to ensure an adequate and trained workforce will be available to deliver care under transformed models.

5. Coordination with Other Federal, HHS, and CMS, or Local Initiatives

Statewide transformation of the deliver and payment methods for health care will inevitably involve other federal health care programs such as Medicaid, Medicare and programs at agencies including CDC, HRSA, SAMHSA and AHRQ.

States should coordinate Innovation Plan development with other State or federal/HHS/CMS/and CMMI initiatives including, but not limited to:

- i. 1115a Medicaid Demonstrations
- ii. Medicaid-led transformation efforts, such as Health Homes, ACOs, and Patient-Centered Medical Homes
- iii. Comprehensive Primary Care Initiative integration
- iv. Medicare Advanced Primary Care
- v. Initiatives from related agencies including CDC, HRSA, SAMHSA and AHRQ
- vi. Insurance Marketplaces
- vii. Regional health improvement collaboratives
- viii. Community benefit programs sponsored by non-profit hospitals/businesses
- ix. Local public health department activities
- x. Higher education programs
- xi. Other key local initiatives sponsored by city, county or regional public health commissions, large employers, academic institutions, professional societies, community organizations, etc.

A complete list of the Center for Medicare and Medicaid Innovation initiatives is available on the [CMMI website models page](#).

6. Technical Assistance (TA)

A broad range of technical assistance (TA) is available to Model Design awardees. Coordination and provision of TA is managed through the SIM Technical Assistance Solution Center (TASC), a Salesforce-based tool available to awardees, contractors, federal partners, and SIM POs. A webinar-based training will introduce the TASC to new awardees. Additionally, a PDF training guide that provides an overview of the system can be found in Appendix A of this document. The training guide also includes a list of available TA categories. Tools and resources produced as a part of TA administration can be found in the Library on the Collaboration Site to be accessible soon at this link:

<https://collaboration.cms.gov/?q=library>.

Appendix A

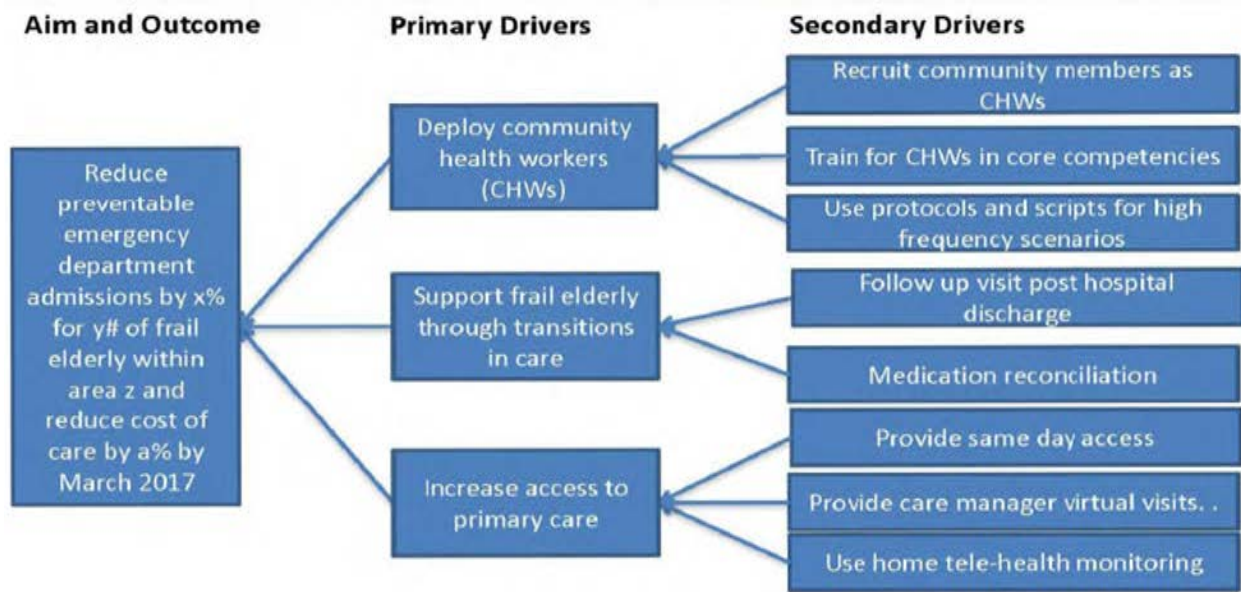
Technical Assistance

Webinars on the available technical assistance and a guide to the TASC order system for requesting technical assistance will be provided in late February.

Appendix B

Driver Diagrams

A discussion on how to develop appropriate Aims, Primary Drivers and Secondary Drivers is available here: [CMMI Driver Diagram Guide](#)



The Companion Workbook contains a tab with a suggested format for developing your specific driver diagram.

Appendix C

Round 1 SIM Model Design State Health Improvement Plans

State	State Health Care Innovation Plan
California	http://www.chhs.ca.gov/PRI/CalSIM%20State%20Health%20Care%20Innovation%20Plan_Final.pdf
Colorado	http://coloradosim.org/wp-content/uploads/2013/12/SIM-Final-12-12-13.pdf
Connecticut	http://www.healthreform.ct.gov/ohri/lib/ohri/sim/plan_documents/ct_ship_2013_12262013_v82.pdf
Delaware	http://www.dhss.delaware.gov/dhcc/cmimi/files/choosehealthplan.pdf
Hawaii	http://hawaiihealthcareproject.org/images/pdf/policy-papers/Hawaii%20Healthcare%20Innovation%20Plan_February%202014.pdf
Idaho	http://healthandwelfare.idaho.gov/Portals/0/Medical/SHIP/IdahoSHIP.pdf
Illinois	https://www2.illinois.gov/gov/healthcarereform/Documents/Alliance/Alliance%20for%20Health%20paginated%20174pg%20WEB%2004-08-14.pdf
Iowa	http://dhs.iowa.gov/sites/default/files/IA%20SHIP%20Final.pdf
Maryland	http://hsia.dhmm.maryland.gov/Documents/SIM%20Plan%20Final%20(compressed).pdf
Michigan	REPORT: http://www.michigan.gov/documents/mdch/Michigan_Blueprint_APPENDICES_REMOVED_454499_7.pdf APPENDICES: http://www.michigan.gov/documents/mdch/Michigan_Blueprint_APPENDICES_FINAL_DRAFT_454500_7.pdf
New Hampshire	http://www.dhhs.state.nh.us/ocom/documents/nh-sim-plan.pdf
New York	https://www.health.ny.gov/technology/innovation_plan_initiative/docs/ny_state_health_innovation_plan.pdf
Ohio	http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=WsSIPFly5GI%3D&tabid=138
Pennsylvania	http://www.portal.state.pa.us/portal/server.pt?open=18&objID=1386300&mode=2
Rhode Island	http://www.healthcare.ri.gov/healthyri/resources/SHIPwithAppendix.pdf
Tennessee	http://www.tn.gov/HCFR/forms/SHIP.pdf
Texas	http://www.hhsc.state.tx.us/hhsc_projects/Innovation/proposal.pdf
Utah	http://health.utah.gov/documents/UtahHealthInnovationPlan.pdf
Washington	http://www.hca.wa.gov/shcip/Documents/SHCIP_InnovationPlan.pdf / http://www.hca.wa.gov/hw/Documents/SHCIP_InnovationPlan.pdf

Appendix D

Definitions

“**Provider Organizations**” are health care related organizations which could be categorized in the following:

- **Hospital** –Organizations that provide inpatient medical care and other related services for surgery, acute medical conditions or injuries.
- **Ambulatory & Independent/Group Practices** –Organizations that provide outpatient services, including community health centers, independent and group practices, cancer treatment centers, dialysis centers.
- **Long Term Care** – Organizations that provide long term, post-acute care and rehabilitative services including nursing homes.
- **Home and Community Based Services**– Organizations that provide opportunities for individuals to receive services in their own home or community.

“**Providers**” are staff employed at/represented by organizations participating in SIM which could be categorized in the following:

- **Licensed Clinicians:** This would include the following types of professionals: Doctor of Medicine (MD); Doctor of Osteopathic Medicine (DO).
- **Other Licensed Professionals:** This would include the following types of professionals: Physician Assistant (PA); Nurse Practitioner (NP); Clinical Nurse Specialists (CNS); Doctor of Dental Medicine (DMD); Doctor of Pharmacy (Pharm.D).

Allied Health Professional: This would include the following types of professionals: social worker, physical therapist, dental hygienist, care coordinator, community health worker, and medical interpreter.

“**Beneficiaries/members/enrolees**” are individuals who receive any healthcare related services by the organizations participating in SIM.