State Innovation Model

Part 2. Sustainability Plan

April 18, 2019

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SIM in Delaware

On January 31, 2019, the state of Delaware concluded its Federal grant under the State Innovation Model (SIM) program. SIM tests state governments' ability to use their policy and regulatory levers to accelerate health transformation. Delaware worked towards this goal by pursuing the Triple Aim Plus One – with the Plus One focused on provider satisfaction and engagement. Our SIM efforts will continue into strategic areas of sustainability that stemmed from testing and learning in key areas, including key opportunities to use data transparency and investments in primary care. Delaware's Health and Social Services "Road to Value" includes seven strategic initiatives to help improve the quality of care and reduce the cost of health care in Delaware. These initiatives include: 1) accelerate payment-reform readiness; 2) establish cost and quality benchmarks; 3) strengthen primary care; 4) advance behavioral health integration; 5) establish a health care claims database; 6) advance and shift Healthy Neighborhoods work to a new entity; and 7) engage patients and consumers. These goals set the blueprint for change that health care institutions and providers will be working to implement as we move forward.

As Delaware continued to innovate in 2017 and 2018, we began the process of investing in provider readiness and preparedness for new payment models. This process has included stakeholder engagement, resource identification, policy and payment reforms that incentivize adoption, and other activities to ensure that we maintain and make further progress. We have explored state levers that will be useful to move towards total cost of care payment models, transformation under Medicaid, and new conversations with the health care spending and quality benchmarks. We feel strongly that the partnerships built, the progress made, and the lessons – good and bad – learned will help us be effective in continuing to move forward.

The four main drivers in SIM Award Year 4 focused on payment reform, practice transformation, population health promotion, and health information technology. These focus areas included and built on activities in workforce supports and reforms, stakeholder engagement and input, and infrastructure to ensure accountability.

Payment Reform

Progress Made

A major achievement of this final year of SIM was the development and launch of the Health Care Spending and Quality Benchmarks. This tool will help us get a handle on the cost and quality of our state's health care system and serve as a beacon in our efforts to understand and manage the total costs of care across populations, communities, and payers.

Throughout the SIM grant period, we have sought to engage with public and private payers to advance reforms that support and lead to transformation. At the halfway mark, when the Carney Administration came on board, an examination of SIM progress to date highlighted the large gap between the goal of value-based health care payment models and the capacity of

Delaware providers to bear risk and manage to the total cost of care. At the direct guidance from the Centers for Medicare and Medicaid Innovation, Delaware was encouraged to make greater progress in value-based payment reform efforts. We had to take a close look at readiness for payment reform and reorientation towards opportunities to accelerate practice transformation.

Our Medicaid MCO contracts launched new contracting levers starting in January 2018. The initiative stemmed from a lack of stakeholder consensus on contracting strategies that now allows for multiple pathways to engage in value-based conversations. The MCO contract approach has two key parts: quality performance measures and value-based purchasing strategies. Through quality performance measures, Medicaid will select measures that relate to the following: quality, access, utilization, long-term services and supports, provider participation, spending and/or member/provider satisfaction. Key measures build on the Common Scorecard created in collaboration with the SIM Award and through the Delaware Center for Health Innovation's work. In the three years of this contract, seven key measures will be monitored including management of diabetes cases, asthma management, cervical cancer screening, breast cancer screening, obesity management, timeliness of prenatal care and 30-day hospital readmission rates.

These measures also will be tied to desired performance levels, with potential penalties being imposed if performance levels are not achieved. Through the value-based purchasing strategies, the managed care organizations will be required to implement provider payment and contracting strategies that promote value over volume and reach minimum payment threshold levels. If minimum threshold levels are not met, potential penalties could be imposed.[1]

Recently, the Division of Medicaid and Medical Assistance (DMMA) released a Request for Information (RFI) to explore the viability and approach to Accountable Care Organizations (ACOs) that best fits Delaware Medicaid. We are currently reviewing those responses in the second quarter of 2019 to evaluate how the state may pursue a formal request for proposals for Medicaid ACOs. The state may pursue a formal request for proposals.

In January 2017, Highmark introduced "True Performance" a value-based reimbursement program for Primary Care Physicians focused on affordability and quality of health for Highmark members. Included in True Performance is Highmark's Medicaid MCO population.

Additionally, based on the direction of the State Employee Benefits Committee, the State Employee Benefits Office completed a RFP and recently launched a new bundled payment model referred to as the Centers of Excellence model for the upcoming 2020 benefits year. The Centers of Excellence allows the state to help patients navigate high quality and significantly lower cost sites of care for a range of elective procedures. Additionally, through steerage and co-pay design, the State Employee Benefits Committee is exploring other activities that will lower costs for covered procedures and services. Another example of the ongoing collaboration

[1] For more information, see attached Appendix 1

between DHSS and the State Benefits Office has also led to an ongoing exploration around joint drug purchasing and contract opportunities with some external support from the National Academy of State Health Policy. This arc of reform for our public payers will continue in 2019 and beyond.

Later in 2018, DHSS launched 11 total pilot projects across ten provider organizations, with over $1 million SIM funding to test out and implement rapid, focused reforms. 48 entities from across the state applied for these grants, and the 11 pilot programs launched will serve as learning labs for other providers. We selected these grantees not just for the quality of their proposals, but also to have them serve as guides for other providers and payers about what works and what can be obtained with investment in provider-led innovations. Many of the grantees were able to report successful workflows and progress that should lead to sustainable outcomes. Grantees were enthusiastic about implementing long-standing ideas and they are excited to monitor outcomes going forward beyond the grant period. Of note, some of the readiness to engage in a Medicaid ACO, global hospital budgeting or population level-alternative payment models were built into the foundation of these successfully executed mini-grants.

Also, later in the grant cycle, leadership of three Delaware Federally Qualified Health Centers (FQHCs) – Westside Family Healthcare, Henrietta Johnson Medical Center, and La Red Health Center – expressed an interest in Alternative Payment Models. Two models of value-based payments were discussed; 1) a capitated approach to Prospective Payment System (PPS); and 2) Medicaid shared savings on total cost of care. The FQHCs engaged in these discussions pursued further discussions with DHSS leadership, Dr. Kara Odom-Walker (Secretary, DHSS), Stephen Groff (Director, DMMA), and Dr. Elizabeth Brown (Medical Director, DMMA), who will continue to research and consider various alternative payment models for provider groups, not limited to FQHCs. We look forward to the ongoing exploration and model development efforts in partnership with the FQHCs in our state.

Lessons Learned

Providers are willing to adopt new methods of practice, leading to improved integration and therefore quality, but only if payment models are adapted to help stand up, reward, and sustain these changes. To accomplish this requires:

- Proactive efforts to explore and implement new payment models,
- Dialogue between payers and providers to align incentives with expected outcomes, and
- Cooperation among payers (i.e., MCOs) to align models with provider capacities.

During SIM, we encountered multiple challenges in achieving alignment among payers (public programs and private sector-based efforts). While there are many initiatives, and isolated examples of success underway and contemplated, the fragmentation and competing directions limited the impact. This was further exacerbated by the many small and independent practices in Delaware—without the means or capacity to take on multiple improvement efforts. As we

look to sustain our progress and efforts made in payment reform, the lessons learned from the multiple challenges in achieving alignment among payers highlight the critical need for providers and payers to move forward together in unison and supporting broad participation across provider types and communities. These conversations will continue in multiple venues, including monthly Health Care Commission meetings, newly enacted Primary Care Collaborative, and monthly Delaware Center for Health Innovation Payment Reform Committee meetings.

What Will Continue?

Governor Carney and his executive team have recognized the need for and consistently pressed forward on a payment reform agenda. Working with the legislature and with many stakeholders, the Department of Health and Social Services and other state agencies will continue to drive reform efforts and continue to focus on reducing the costs of care while sustaining and improving the quality of outcomes and overall health. Without new models of payment, other goals of practice transformation and population health will not thrive. Efforts to forward new payment models will lead to the continued spread of value-based payment and collaboration among private and public entities. Furthermore, reform efforts must include more and better analytics and reporting to mark our progress and hold ourselves accountable. The healthcare spending and quality benchmark activities and value-based purchasing in managed care contracting will continue post-SIM. Specifically, we will continue to build on the foundational work to pursue global hospital budgeting models, population-level payments, Medicaid ACO-arrangements, and transformational systems of care for our most vulnerable.

Benchmark

The SIM investments in Benchmark activity will create a transparent lever across all payers and large providers to engage in payment reform activities to keep the growth of spending at a sustainable level and improve quality. As we have seen in Massachusetts, their benchmark activity has driven quality improvement and cost containment.

As described in Executive Order 25, signed into effect in November of 2018, Delaware's Health Care Commission (HCC) will have primary responsibility for measuring the performance of the state's providers and payers against cost and quality benchmarks. Cost and quality benchmarks have been set for 2019, and an Implementation Manual has been developed that clarifies the methodology for measuring performance and setting benchmarks in the future. The manual lays out the technical steps to implement the benchmarks and provides a road map for the important activities that will be occurring in the future. The Department of Health and Social Services is excited to help champion the implementation of the benchmarks, along with our state partner, the Delaware Economic and Financial Advisory Council. While the manual represents a significant achievement, much work is yet to come to operationalize fully the benchmark data collection and public reporting process. Working together, we can support the goal of making sure Delawareans can access and afford quality health care. The benchmarks are the start to a conversation about how to improve cost and quality for the individuals we

serve as patients and members in our communities. The Governor's Recommended Budget for FY2020 includes support for the data needs and analytic support.

- What is needed?
    - Analytic capacity in agencies and a transparent process to adapt and respond to findings
    - A focused effort to use the benchmark, including continued public communications, and accountability, revisions and expansions to the benchmark over time
- Who will drive this process?
    - The Governor, through transparency and accountability under the Health Care Commission and the Delaware Economic and Financial Advisory Committee
    - Our public payers: Medicaid, state employees' health plan, Delaware Division of Substance Abuse and Mental Health, etc. with initiatives like value-based purchasing (VBP) requirements, accountable care organizations, and care improvement incentives
    - The Delaware Economic and Financial Advisory Council (DEFAC) will review and approve any modifications to the Health Care Spending Benchmark or the Health Care Spending Benchmark methodology as proposed by the DEFAC Health Care Benchmark Subcommittee.
    - DHSS-driven efforts will provide oversight and support of the Benchmark related activities assigned to the Health Care Commission and Division of Medicaid and Medical Assistance.
    - Private payers by making payment reforms to support better Benchmark outcomes
    - Health systems though efforts to measure their own performance and make changes in practice based on what the benchmark tells us
- How can stakeholders support the Benchmarking effort?
    - Within their organizations, identify benchmark-related opportunities to make change. Although we do not intend to publish provider or plan level data, it is possible for individual entities to conduct their own internal benchmarking process
    - Explore opportunities to do your own analysis and/or benchmarking process. What metrics can you impact in your workplace or community? The state and others can provide tools to assess and analyze these topics, and to foster changes that will ensure accelerated progress.
- How will we know it is working?
    - Improvements in benchmark metrics through our mutual focused attention.
    - Entities staying at or below the benchmark each year.
    - Data will identify specific examples where Delaware providers and communities are driving improvement and share best practices.

    - As the benchmarking process and state capacity matures, accountability for performance can be woven into payment reforms.
- What will be sustained?
    - The healthcare spending and quality benchmark activities and value-based purchasing in managed care contracting will continue post-SIM.

New Payment Models

Early in 2018, Medicaid launched a major new effort to implement value-based purchasing in their managed care contracting. Over the coming years, Medicaid and the contracted health plans will further refine their approach and progressively move more payments into these arrangements, with a goal of at least 60% of Medicaid expenditures being in value-based payments by 2022. The State is utilizing its contracting levers with minimum threshold levels and potential penalties if not met.

Likewise, the Government Health Insurance Program (GHIP) has been implementing a Centers of Excellence model with its health plans to encourage consumers to make sound value decisions and encourage the use of higher-quality providers. They will grow this initiative over time as well.

Because Delaware has only a handful of health plans, there is real opportunity to align payment reforms across payers and plans. While this is far more challenging to do than to say, public and private market stakeholders need to continue to find ways to work together. But without alignment and a unified agenda of payment model adoption, progress will be fragmentary. Small providers will be left behind, and consumers across Delaware will not achieve the outcomes they deserve. There is an opportunity for a more unified or coherent payment reform effort. The state will outreach to payers and provider groups to work together and making tracking and reporting on progress toward VBP arrangements within the scope of state entities such as the Delaware Health Information Network (DHIN), HCC, or the Delaware Center for Health Innovation (DCHI).

- What is needed?
    - The continued commitment of public agencies to implement and refine value-based payment models.
    - A forum for public and private stakeholders to come together. Post SIM, this will be more difficult and could fall into disarray without the allure of major funds. However, SIM has already brought entities together to plan and implement VBP models, and with commitment, that work can continue.
- Who will lead the effort?
    - Public payers, specifically DMMA and GHIP, will continue to lead the way to reform through contracting levers.
    - Private payers and health system leaders—including our health plan partners, private industries and others can implement continued innovation and payment

reform—aligning with others with the benchmarks providing a beacon for total health expenditures and the potential of the DHIN's HIE and HCCD being a robust source for data analytics and for high-level analysis on spending and quality trends

- What can stakeholders do?
    - As noted in lessons learned above, the best practices in new payment models come when providers and payers work together. Looking to other states who have moved farther along than DE, we can see that a sense of unified purpose and a drive to align and improve leads to systemic changes. We hope that providers and payers will commit to continuing to work together, post-SIM. It is our hope that the Benchmark, the health care claims database, and other transparency initiatives can fuel this unifying effort.
- How will we know new payment models are being implemented?
    - As noted above, progress on the Benchmark will indicate success in other aspects of transformation.
    - Both DMMA and GHIP's programs have public-facing aspects and will demonstrate the spread of VBPs in these programs.
- What will be sustained?
    - The state will continue to work with payers and provider groups to encourage VBP arrangements and increased up front investments. The Delaware Primary Care Collaborative will continue to meet, host public meetings, and convene stakeholders.

Payment Reform Readiness Investments

Early in 2018, DHSS through SIM, explored the readiness of Delaware providers to take on various payment reforms. Through this study, two things were clear; first, providers in the state were committed to and interested in adopting new models; and second, most providers had substantial gaps in their capacity to adopt and flourish in new payment models.

Using a sizable portion of remaining SIM funds, Delaware invested in several key efforts to move toward greater readiness. Among other activities, the state released grants for provider-led readiness efforts. Although these were focused efforts for a subset of Delaware providers, we expect there to be vital lessons for all of us in moving toward greater readiness.

- What is needed?
    - A forum to share lessons learned and best practices from these granted programs of work and other payment readiness efforts (SIM-financed or otherwise)
    - Adoption of these reforms by other providers in the state
    - Support from health plans and others for the spread of these efforts after SIM funds are depleted
- Who will lead the effort?

    - Providers themselves came forward to take on these challenges and will be the leaders for future efforts to prepare Delaware practices to take on new payment models
    - The Health Care Commission will continue to engage with stakeholders to share lessons learned and disseminate findings.
- What can stakeholders do?
    - Plans, payers, and government agencies can help with data, funding, tools, and other supports for these efforts.
    - Ongoing dialogue around investments in payment reform readiness
    - Stakeholders are encouraged to bring new and innovative models that they have developed to the appropriate payors. We encourage provider led initiatives that meet the goals of the triple aim and road to value.
- How will we know we are improving provider readiness?
    - More providers are participating in VBP arrangements, including through Medicaid, and are successfully controlling costs. The mini grant investments added to the inventory of providers ready to engage in arrangements.
    - Risk-sharing arrangement are expanding in number and complexity.
- What will be sustained?
    - The work to invest in primary care was supported by Senate Bill 227 and includes provisions to continue to explore the needs of the primary care community and workforce for value-based payments
    - The Delaware Health Information Network continues to build capabilities to support payment reform readiness through its Health Care Claims data base and other clinical information exchange efforts.
    - Contracting levers are a path to sustainability. An example of this is the Medicaid MCO/ACO RFI that was released. We are now in the process of reviewing proposals.
    - We also are engaging a conversation around an APM option with a FQHC.

We are proud of the progress Delaware has made in payment reform efforts, but must acknowledge that we have a long way to go—in building provider capacity, in aligning across payers, and in taking every opportunity to manage Delaware's total costs of care.

Practice Transformation

Progress Made

Throughout SIM, several efforts were made to support changes at the individual provider level. Coupled with payment reforms, these efforts have the potential to be self-sustaining. Furthermore, change can spread to other processes within participating practices. Once the systems and the culture shift to adapt to one new process, they can expand to accommodate other changes.

Early in the grant, the state worked with more than 100 practices to make changes in work flow, patient management, and other aspects of care to improve overall system performance in primary care. In 2017-18, practice transformation efforts intensified and focused on an impactful and timely topic – behavioral health and primary care integration. More than 25 providers across the state, and from both physical and mental health practices, participated in tailored and immediate practice reforms to support Behavioral Health – Physical Health (BH-PH) integration. These providers made significant commitments and are reaping the results: with improved care coordination, more consistent referrals, care planning, and information sharing among providers. Related payment reforms are underway in Medicaid and beyond, but more work needs to be done at both the payer and provider level. Several materials and tools were deployed in this effort and can be used by other Delaware practices in the future.

Throughout SIM, there were several efforts to address specific workforce issues—including training, availability, and overall health of the workforce pipeline. Late in the SIM cycle, the state legislature formed the Primary Care Collaboration to explore the current challenges facing Delaware's primary care workforce and to offer pathways for improvement to strengthen primary care in Delaware. This was an opportunity to build off earlier SIM experiences in practice transformation and workforce and further refine the road ahead.

Lessons Learned

As noted, there is a considerable gap between the capacity of providers to bear risk for costs of care and the need for getting a firm grip on Delaware's total cost of care. Providers are willing to adopt new methods of practice, leading to improved integration and therefore quality, however, if payment models are not adapted to reward these behaviors, there is no incentive for them to change. Additionally, for many providers securing up-front funding to make the necessary changes to accept value-based payments will be the difference between embarking on the Road to Value or staying mired in Fee-for-Service. There needs to be ongoing engagement among providers, payers and the state to keep progressing toward RTV future state.

What Will Continue?

Behavioral Health Integration

- What is needed?
    - As we know from this work, changes at the practice level can result in significant improvements in care coordination and patient management. More Delaware practices should engage in this work through Medicaid and State Employee Health Plan value-based contracts. We are currently looking into some Health Home models to access enhanced match for integrated services. The concept of course is not only to look at the funding mechanism but to enhance the comprehensive menu of services we need to offer individuals with substance abuse and mental health disorders with their physical health. We know there have been many lessons learned with this CMS initiative and are undertaking an

exploration of the concept. SIM resources such as assessment tools, and training materials, developed to support BHI effort will be made available for practices to access post SIM.
    - Payers should invest in sustaining these practice reforms. Practices must invest time and resources in care improvements, and our payment models from public and private payers must be structured to support—even incentivize these necessary practice reforms.
    - A vibrant data exchange environment to support care coordination, team-based care, and outcomes tracking as patients move among providers. This would include consistent and inclusive use of health information exchange, patient registries, community health records, and behavioral health data exchange like DTRAN and assessment data.
- Who will lead the effort?
    - The provider community can and must assume leadership in practice transformation
    - The State will continue to work towards care coordination and behavioral health integration to address the opioid crisis and behavioral health system transformation required for a robust state-response
    - DHSS will continue to explore bundled payment strategies for behavioral health integration with quality incentives along with system transformation opportunities embedded in potential Medicaid ACO strategies
- What can stakeholders do?
    - This provider commitment to BHI should be supported by payers, through data sharing and analysis, payment reforms, and other resources
    - Academia and others with capacity can help providers with technical assistance and training
    - DHSS will host the tools and trainings developed under SIM so other providers can take advantage of these resources after SIM ends
- How will we know BHI working?
    - There are numerous indicators, in Healthcare Effectiveness Data and Information Set (HEDIS) and elsewhere, or quality of care and care coordination.
    - Even as SIM ends, Delaware is ramping up to address the opioid epidemic and addiction issues. Continuing with BHI efforts should lead to improvements that will affect this challenging arena.
- What will be sustained?
    - Our major hospitals have undertaken much of this work. They are seeing this as a critical part of their pathway to value. Many of our hospitals and children's hospital are engaged in a robust path to integration of behavioral health and physical health through their programming and CIN development.

Primary Care Workforce Development and Support

Throughout SIM, Delaware has made several specific efforts oriented to address issues in the state's workforce—be they payment reform capacity, workforce challenges, or technical assistance with practice transformation. Through SIM, the state has supported primary care practice transformation for over 100 practices and behavioral health integration for 28 practices. In SIM AY4, Delaware sponsored a consumer and provider roundtable discussion on June 19, 2018, that help inform legislative hearings. Most recently, SIM has focused on issues in primary care through the Primary Care Collaborative (PCC). Created by the Delaware General Assembly with the passage of SB 227 in August 2018, the Collaborative is making recommendations on ways to strengthen the primary care system in the state. Policy levers may include payment reforms that favor primary care, incentivizing medical students to go into primary care, and providing technical assistance to reduce fragmentation and improve coordination of care. The conversations are quite active currently for this legislative session and will continue for the next three years as stated in the enacting legislation.

- What is needed?
    - Ownership for adopting and implementing recommendations from the Collaborative.
    - Public and private coordination among payers and others to support and strengthen capacity of the primary care system.
    - Improved data sharing and reduce barriers to communication across providers—including primary care, pharmacy, acute care, etc.
- Who will lead the effort?
    - For payment reforms and policy changes: The Collaborative members (Chair of the Senate Health, Children & Social Services Committee, Chair of the House Health & Human Development Committee, and Chair of the Delaware Health Care Commission). The Governor and General Assembly have been supportive.
    - For workforce supports: The Medical Society of Delaware, academia, Delaware Health Information Network, the Delaware Institute of Medical Education and Research program under HCC, and others must be proactive in supporting the primary care workforce.
- What can stakeholders do?
    - Public commitment to a strengthened primary care system is important. One of the reasons primary care has struggled is a lack of focus of leaders from all sectors. Without focused attention, including shared and concerted commitment to forwarding the recommendations of the PCC, Delaware's primary care capacity will be further weakened.
- How will we know the primary care system is working?
    - Quality indicators of strong primary care include care coordination metrics, reduced readmissions, and improved chronic disease management and ambulatory-sensitive conditions measures. Additionally, one of the Quality

Benchmarks under the Governor's Executive Order 25, the Emergency Department utilization rate, was specifically added as a way to track the robustness of the primary care infrastructure in Delaware.
    - More entrants to the field—including more physicians and other primary care providers are practicing in the state.
- What will be sustained?
    - With the enactment of SB 227, annual reporting to the Health Care Commission will include:
        - Monitor spending on primary care
        - Measure progress on transitioning from fee-for-service to value-based payment for health care services
        - Provide oversight for health care workforce development in the state
        - Evaluate how primary care supports state efforts on meeting its benchmark for controlling health care spending
    - SB 227 requires certain payers to set primary care reimbursement rates at level no less than Medicare rates, as well as requires certain payers to pay chronic care management fees, modeled on Medicare CMM monthly fees.

Population Health

Progress Made

From almost day one, population health improvement through community engagement was an important part of SIM. Early on, stakeholders gathered to discuss possible ways to address these issues. This built strong engagement, it was not until action agendas and targeted grants were made available that significant progress was made. Communities created partnership agreements, and selected priority areas of need. Using evidence and technical assistance available through SIM, they applied to implement programs that would address specific challenges each community faced. These grants funded a wide-ranging set of activities, but all with the intent and capacity to improve select population health metrics.

Simultaneous to these Healthy Neighborhood demonstration grants, the SIM team sought a more lasting solution—one that would continue to support community-level action and innovation beyond SIM. This effort to recruit possible funders, identify thought leaders and get stakeholder input on the future of this effort culminated in the launch of Healthy Communities Delaware. Potential funders, public health leaders, academia and local community coalitions will work together to perpetuate population health interventions.

Finally, the HCC worked with the Division of Public Health to generate a data repository that will help guide and evaluate population health initiatives. The Population Health Scorecard will provide communities with an understanding of their challenges and contributing factors. This will assist them in targeting initiatives that will reduce the cost of care and improve health

outcomes. The Scorecard can also track progress over time and may align with the Cost and Quality Benchmark effort in future iterations.

Lessons Learned

Local leaders are committed to implementing programs that will improve population health. But this commitment is not enough. It takes considerable effort to effectively implement evidence-based interventions. Furthermore, possible funders are not aligned well with these local coalitions or struggle to ensure their investments are effective. Linking passionate local leaders with consolidated funding opportunities—and then supporting implementation will be more successful and lasting. And successful implementation must be supported by data that can be used at the granular and broader by communities and the state to identify barriers to population health improvement and guide new policy and local interventions.

What Will Continue?

The Healthy Communities Delaware (HCD) effort has built on the momentum and collaborative action of local coalitions to garner the support and engagement of many key players in Delaware. Funding sources are banding together to support future initiatives. But there are two resources necessary to the long-term success of this joint endeavor, 1) technical and fiscal assistance and evaluation support through a set of "backbone organizations" and 2) community level data to drive sound interventions and assessment of results.

Backbone Organization

- What is needed?
    - The University of Delaware, in partnership with the Division of Public Health have established an investment council to gather and channel funding for population health initiatives. A portion of this Council's resources will go to funding the backbone organization (BBO), but other resources may be required.
    - The BBO will not be one entity, but three in an established partnership between DHSS, University of Delaware, and the Delaware Community Foundation: including fiscal and organization support for the investment council and for grantees, technical assistance for grantees, and monitoring and evaluation of program implementation.
    - Continued local support, convening, and engagement in priority setting and implementation.
- Who will lead the effort?
    - The Community Investment Council and the Leadership Council will lead the efforts to perpetuate local initiatives and support the launch of the backbone organization.
    - Local Coalitions must continue to work together to identify community priorities and interventions to improve population health.
- What can stakeholders can do?
    - Contribute expertise to the backbone organization and the Investment Council.

    - Participate in the Community Investment Council—offering both financial support for local initiatives and helping to support the Backbone structures.
- How will we know HCD is working?
    - Local initiatives will be implemented effectively—thereby attracting additional investment.
    - Local councils will continue to be engaged and committed to healthy community planning and implementation.
- What will be sustained?
    - HCD was officially launched January 14, 2019, as a sustainable mechanism for the continuation of the Healthy Neighborhood efforts. HCD hosted, "Aligning for Better Health Symposium" attended by over 170 stakeholders. The symposium featured a panel highlighting the collaborative work happening in each of Delaware's three counties and breakout sessions gathering information about the current health needs and existing programs in each county. HCD is committed to effective and sustainable ways of investing in our local communities to reduce the health disparities that exist from one zip code or neighborhood to another. HCD Leadership Council and management team will continue to work hard to facilitate collaboration across sectors, disciplines, and jurisdictions to intensify the impact we can have collectively on improving the health and well-being of our communities and their residents.

Population Health Scorecard

- What is needed?
    - Aggregate and locally discernible data on population health metrics relevant to the total cost of care and the quality of health and health care services.
    - A dashboard supporting local communities in prioritizing interventions and tracking progress over time.
    - Alignment between payers, policy leaders, and communities about how to tackle the social determinants of health. This will eventually include linkages between the Cost and Quality Benchmark and the Population Health Scorecard.
- Who will lead the effort?
    - The Division of Public Health will be the primary provider of data to the scorecard and will support the Scorecard going forward.
    - Health Care payers, DHIN, and others can be data contributors.
- What can stakeholders can do?
    - Local community leaders should use this data in setting agendas and ensuring effective interventions.
    - The Healthy Communities Delaware steering committee should utilize the Dashboard in making decisions and targeting funding resources.
- How will we know the Population Health Scorecard is working?

- Local initiatives will be targeted to evidence-based practices and evaluated consistently against the scorecard.

- What will be sustained?
  - DHSS will release the innovative software platform My Healthy Community to deliver neighborhood-focused public health information to the public in spring of 2019. My Healthy Community will become the home for the DE Population Health Scorecard. Population Health Scorecard data will be presented about local neighborhoods throughout DE, as well as aggregated to town, county and state geographic resolutions. Ongoing enhancements to the work to be made throughout the 2019 calendar year as additional population health indicators are loaded into the software framework.

Health Information Technology (HIT)

Progress Made

SIM made several investments in Health IT throughout the grant period, working with DHIN on different projects. Most recently, SIM supported the final steps toward the launch of the Health Care Claims database (HCCD) and technical assistance on data collection and alternative funding sources.

HCCD

SIM made several investments in Health IT throughout the grant period, working with DHIN on different projects. Most recently, SIM supported the final steps toward the launch of the Health Care Claims database and technical assistance on data collection and alternative funding sources.

The HCCD was created by the DE General Assembly on June 30, 2016, through passage of SB238 which amended 16 Del.C. Ch. 103, Subchapter II.[2] The legislation established the HCCD to facilitate data driven, evidence-based improvements in access, quality, and cost of the Delaware healthcare delivery system and to promote and improve public health through increased transparency of accurate claims data and information. To accomplish these objectives, the legislation charged DHIN with administering and operating the HCCD and granted DHIN the authority to collect claims and enrollment data from public payers (Medicaid, Medicare), and certain private payers. The legislation became effective on January 1, 2017 and DHIN promulgated the rules and regulations pertaining to data collection in October 2017.

Data submission to the HCCD began in mid-2018, with the collection of five years' worth of historic data (2013-2017) from State Employee Health Plans, Medicare Advantage Plans, Qualified Health Plans doing business on the Delaware Health Insurance Marketplace, and Pharmacy Benefit Managers. Due to the necessary legal agreements and data mapping work, data submissions from Medicaid FFS, the State's two Medicaid MCO plans, and Medicare FFS (CMS) will begin in early 2019

[2] http://delcode.delaware.gov/title16/c103/sc02/index.shtml

Since the enabling legislation was first passed in 2016, the HCCD has been funded entirely through CMS' SIM grant, as it directly advances the state's goals of system transformation and progress against the Triple Aim of better health, better healthcare, and lower costs. DHIN has also contributed in-kind staff support and resources to planning, development, and management for the entirety of the project. In addition, DMMA and commercial payers have invested considerable funding and staff resources into the database by configuring their data to comply with technical specifications, submit the data monthly, and perform quality assurance.

Lessons Learned

DHIN is an essential partner to the state in the sustainability and advancement of many payment reform and practice transformation initiatives. Establishing governance, concrete deliverables, and agreements between DHIN and state agencies are necessary for the state to ensure that progress continues, and expectations are met.

What Will Continue?

In several legislative actions, the Delaware General Assembly has sought to stimulate the development and deployment of a multi-payer Health Care Claims Database (HCCD). These included requiring public and private payers to send data to DHIN for this purpose. When fully functional, the HCCD could be an important resource to several transformation efforts, but also a potentially useful tool among plans, providers, and researchers as to the wellbeing of the Delaware health system and evidence of where focus is needed to drive improvement.

DHIN will continue to promote, establish interfaces, and onboard practices to its Health Information Exchange services, including the Community Health Record, Hospital and ED alerts, Clinical Gateway, and results delivery, as well as others.

Health Care Claims Database

- What is needed?
    - All payers contributing data to ensure a vibrant and complete picture as stated in Senate Bill 227.
    - Analytic capacity—either at DHIN or elsewhere—to ensure that data from the HCCD is a useful and accurate tool for measuring the state of Delaware's health system.
    - Sustainable funding in the form of an I.A.P.D. with Medicaid could support current operations and future needs.
- Who will lead the effort?
    - DHIN will house the HCCD and could be the analytical lead as well.
    - DHSS and State Employee benefits as key health care data sources should work collaboratively with DHIN to identify opportunities for future development of the HCCD.
- What can Stakeholders do?

    - Public agencies, payers, researchers, should both contribute data and use the HCCD as a tool for guiding decisions, payment reforms, and program evaluation.
- How will we know the HCCD is working?
    - DHSS has representation on the DHIN Board
- What will be sustained?
    - Based on budget bill funding of $2M over the next two years, the state is committed to collaboratively submitting a request for ongoing funding support through an IAPD and Medicaid funding initiatives
    - Sustainability includes the platform in which the claims data is housed (a data lake for ingestion and staging of "raw" data, a data warehouse where the data is made available for analytics, ETL tools, analytics and business intelligence software)
    - Sustainability also includes the human resources, both employed and contracted, to ingest, process, validate, load, transform, enrich, and analyze the data.

Health Information Exchange

- What is needed?
    - Continued growth in the number of practices contributing data to the Community Health Record
    - Consent-based data sharing mechanisms for behavioral health data.
    - Interface with Prescription Monitoring Program (PMP) to allow for practices to view dispense data within the context of other health information and without having to navigate multiple systems.
- Who will lead the effort?
    - The HCCD and other state agencies should drive these initiatives as part of various initiatives throughout the upcoming years
- What will be sustained?
    - The DHIN Community Health Record – the longitudinal record of health data, available for query and retrieval by properly privileged users based on their role and level of permissions.
    - Electronic results delivery, to include interfaces to 31 different EHRs by which results and reports are delivered to over half the practicing providers in Delaware.
    - Event Notification System – ADT-based alerting and notifications of "events" at participating hospitals, EDs, SNFs, and urgent care centers.
    - "Clinical Gateway" – a bulk transfer of clinical data for a defined cohort of patients to support population health and care coordination activities
    - Public Health Reporting (syndromic surveillance, electronic lab reporting, immunization update and query, newborn early hearing screening)

- DMOST Registry – a registry to house end-of-life medical orders and advance directives
- Analytics / reporting service – where allowed by data use agreements, clinical data submitted to DHIN can be analyzed to support ACOs and health systems in various ways.

Current State of "Readiness" for Sustainability by Primary Driver and SIM Activity

	Payment Reform			*Practice Transformation*		*Population Health*		*HIT*	
	Benchmark	***Payment Models***	***Payment Reform Readiness***	***Behavioral Health Integration***	***Primary Care Workforce Development***	***Backbone Organization***	***Population Health Scorecard***	***Health Care Claims Database***	***HIE Connectivity***
Governance	DFAC and DHSS/DHCC implementing benchmark	Public and private payers individually addressing. Opportunities for joint action needed.	DHSS and the Road to Value	Leadership needed to support continued BHI	Primary Care Collaborative (for the time being)	HC-DE coordinating committee	HC-DE coordinating committee	Currently DHIN Board, but future linked to Benchmark	DHIN Board
Accountability	Roles and responsibilities are clarified in implementation plan	Road to Value and Benchmark will drive new models	Providers and payers should continue to come together with ideas	Need to link BHI to value-based payment initiatives and other metrics that drive transformation	State legislature and provider community	Local Councils and HC-DE Investment Council	Local Councils	DHIN and DHSS	Data Contributors
Investments	Areas where investments are required are being identified through implementation planning work	Medicaid, GHIP, and payers have many initiatives underway	Mini-grants can help identify best practices.	Many tools and resources available to support BHI transformation	Post SIM resources not yet identified.	HC-DE Investment Council will help support	DHSS-Div of Public Health	General funds invested	Need greater participation
Stakeholder Engagement	When and how stakeholders are engaged is TBD	Risk of fragmentation is high without coordination	Supports for readiness efforts still needed—particularly in small/indep practices.	Ongoing payer-provider discussions of BHI supportive payment models	Payers and provider systems must support continued transformation efforts	Local leadership and commitment—through councils must be sustained	Need connection between BBO, local councils and Scorecard	Ensure utility and reporting	Buy in from providers and support from payers
Interactions and Dependencies	HCCD Payment models	Benchmark Practice transformation HIE connectivity HCCD	Payment models	Primary care Payment models	HIE connectivity Payment models BHI	Pop Health Scorecard	HIE connectivity Backbone organization	Payment models Benchmark	Payment models Primary care Pop Health Scorecard

	Payment Reform			*Practice Transformation*		*Population Health*		*HIT*	
	Benchmark	***Payment Models***	***Payment Reform Readiness***	***Behavioral Health Integration***	***Primary Care Workforce Development***	***Backbone Organization***	***Population Health Scorecard***	***Health Care Claims Database***	***HIE Connectivity***
Next Steps	Fill in from Benchmark plan	DMMA and GHIP plans	Convene payers and mini-grant recipients to learn. Identify resources to help independent practices with readiness	Share materials from BHI for other practices to use. Continue DCHI meetings on BHI payment reforms	Continue PCC meetings and assess reports for possible next steps by DHSS, legislature and others	Continue to convene the HC-DE leadership groups and identify legis/DHSS funds for backbone support	DPH continue to host the Pop Health Scorecard and support Local Councils	Continue to grow HCCD reporting and capacity. Ensure DHSS has necessary access to drive other steps.	Payers need to both support and incentivize HIE participation

Legend	
	Decision finalized
	In progress, but needs further consideration
	Undecided or risk identified

Benchmark Work Plan/Timeline

Below is a high-level timeline for Benchmark review and reporting. More details are available in Implementation Manual.

	March	April	May	June	July	August	September	October	November	December	January	February
Setting the Spending Benchmark - DEFAC												
Annual review of the components of PGSP for the following calendar year												
Report changes, if any, by May 31 of the year prior to Governor and DHCC												
Announce spending benchmark for following calendar year by July 1												
Performance Assessment of Spending Benchmark - DHCC												
DHCC to update website with file submission instructions												
DHCC-Hosted All-Insurer Briefing to Discuss TME Reporting Requirements												
DHCC Meeting with DMMA to Discuss TME Reporting Requirements												
DHCC Request of CMS for Medicare FFS Data												
DHCC Pulls VA Data												
TME and MLR Reports from Insurers Due												
DHCC Conducts Insurer TME Data Validation and Follow-Up												
TME Data from DMMA Due												
TME Data from Medicare Due												
DHCC Calculates Performance Against the Benchmark and Prepares Publishable Analysis												
DHCC Releases Reports												
Performance Assessment of Quality Benchmark - DHCC												
Set Concurrent Use of Opioids and Benzodiazepines Benchmark 2019 only												
Request data from health insurers to create benchmark - March 31, 2019	2019 only											
Receive data from health insurers - August 1, 2019						2019 only						
Measure and Publish Performance Against the Benchmarks 2019-2021												
DHCC to update website with file submission instructions												
Request the Emergency Department Utilization national observed rate from NCQA - March 31												
Request health insurers submit performance data - March 31												

	March	April	May	June	July	August	September	October	November	December	January	February
Setting the Spending Benchmark - DEFAC												
Receive the Emergency Department Utilization national observed rate from NCQA - August 1												
Receive performance data from health insurers - August 1												
Calculate performance for all measures except for Opioid-Related Overdose Deaths - September 30												
Publish performance data for all measures except for Opioid-Related Overdose Deaths - early November												
Calculate performance for Opioid-Related Overdose Deaths for the performance period two calendar years prior - February 1												
Update published performance data to include Opioid-Related Overdose Deaths - February 28												
Update Benchmarks 2021 -2023												
Commence review of the benchmark measures and methodology to define quality benchmarks for the year beginning 2022 - early January 2021												
Complete review of the benchmark measures and methodology to define quality benchmarks for the year beginning 2022 - September 30, 2021												

Payment Models Work Plan/Timeline

A work plan/timeline should be developed in collaborative with DMMA

			Notable Meeting				*Deliverable Due*				*Time Spent on Task*			
#	**Task**	**Responsible Party**	**1/19**	**2/19**	**3/19**	**4/19**	**5/19**	**6/19**	**7/19**	**8/19**	**9/19**	**10/19**	**11/19**	**12/19**
1														

Payment Reform Readiness Work Plan/Timeline

A work plan/timeline should be developed in collaboration with DMMA

			Notable Meeting				*Deliverable Due*				*Time Spent on Task*			
#	**Task**	**Responsible Party**	**1/19**	**2/19**	**3/19**	**4/19**	**5/19**	**6/19**	**7/19**	**8/19**	**9/19**	**10/19**	**11/19**	**12/19**
1														

Behavioral Health Integration Work Plan/Timeline

			Notable Meeting				*Deliverable Due*				*Time Spent on Task*			
#	**Task**	**Responsible Party**	**1/19**	**2/19**	**3/19**	**4/19**	**5/19**	**6/19**	**7/19**	**8/19**	**9/19**	**10/19**	**11/19**	**12/19**
1														

Primary Care Workforce Development Work Plan/Timeline

			Notable Meeting				*Deliverable Due*				*Time Spent on Task*			
#	**Task**	**Responsible Party**	**1/19**	**2/19**	**3/19**	**4/19**	**5/19**	**6/19**	**7/19**	**8/19**	**9/19**	**10/19**	**11/19**	**12/19**
1	Primary Care Collaborative meetings	Dr. Fan, Sen. Townsend, Rep. Bentz												
2	Primary Care Collaborative report													
2.1	Draft report	Dr. Fan, Sen. Townsend, Rep. Bentz												
2.2	Review of draft report	Dr. Fan, Sen. Townsend, Rep. Bentz												

Backbone Organization Work Plan/Timeline

A work plan/timeline was developed by the University of Delaware

Population Health Scorecard Work Plan/Timeline

A work plan/timeline should be completed in collaboration with DPH

			Notable Meeting				*Deliverable Due*				*Time Spent on Task*			
#	**Task**	**Responsible Party**	**1/19**	**2/19**	**3/19**	**4/19**	**5/19**	**6/19**	**7/19**	**8/19**	**9/19**	**10/19**	**11/19**	**12/19**
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Health Care Claims Database Work Plan/Timeline

A work plan/timeline should be completed in collaboration with DHIN

			Notable Meeting				*Deliverable Due*				*Time Spent on Task*			
#	**Task**	**Responsible Party**	**1/19**	**2/19**	**3/19**	**4/19**	**5/19**	**6/19**	**7/19**	**8/19**	**9/19**	**10/19**	**11/19**	**12/19**
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HIE Connectivity Work Plan/Timeline

A work plan/timeline should be completed in collaboration with DHIN

			Notable Meeting				*Deliverable Due*				*Time Spent on Task*			
#	**Task**	**Responsible Party**	**1/19**	**2/19**	**3/19**	**4/19**	**5/19**	**6/19**	**7/19**	**8/19**	**9/19**	**10/19**	**11/19**	**12/19**
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