

# The State Innovation Model (SIM) Plan: A Practical Guide for Practitioners

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## Background

Health care practitioners, especially physicians, recognize that West Virginia's health care system is at a critical juncture. State budgetary pressures and a deep economic decline are straining all health care insurers, including Medicaid, which accounts for about a third of the state's insurance market. In fact, providers received notices in April 2016 from the state Medicaid commissioner warning that claims processing could be delayed due to the protracted budget stalemate.<sup>1</sup> Even though a government shutdown was averted for the state fiscal year 2017, budget projections for next fiscal year are again in the doldrums.<sup>2</sup> Couple this fact with the state assuming a portion of the Medicaid expansion cost starting in 2017, and it appears increasingly likely that no additional money will be

allocated to the health care system from state governmental sources.

Concurrently, as part of the sustainable growth rate solution to Medicare payments for physician providers, the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 will fundamentally change the way physicians are paid for treating Medicare patients.<sup>3</sup> MACRA will inevitably require physicians to link their Medicare patient panel to some form of quality reporting/clinical improvement or an approved alternative payment model (APM) to either avoid penalties or receive a bonus payment. MACRA compliant APMs are still being finalized, yet the Health Care Payment Learning & Action Network's Alternative Payment Models Framework served as the anchoring framework for West Virginia's State Innovation Model (SIM) grant.

This framework consists of four categories and classifies APMs as generally in category 3 or 4.<sup>4</sup> These category 3 or 4 models include arrangements such as Accountable Care Organizations, bundled payments, certain types of capitation and global budgets. Category 2 models are only considered linked to quality or value. Category 2 models are essentially fee-for-service plus, which encompasses models that reward reporting and/or reward or penalize performance. Category 1 models are fee-for-service only and have no link to quality or value. To better understand the APM framework, it is recommended that the Health Care Payment Learning & Action Network's white paper be reviewed and consulted.<sup>5</sup>

The CMS Innovation Center estimates that as of January 1, 2016, more than 30% of traditional Medicare payments nationally are being made through an APM.<sup>6</sup> The

U.S. Department of Health and Human Services (DHHS) has set a goal of linking 50% of traditional Medicare payments to an APM by 2018 (i.e., category 3 or 4). Furthermore, DHHS has also set a goal of attributing 85% of all traditional Medicare payments to quality or value by 2016 and 90% by 2018 (i.e., category 2, 3 or 4).

MACRA arguably is the strongest signal to date that the Centers for Medicare & Medicaid Services (CMS) is serious about moving health care to a value-based system and away from a volume-based system. The law holds huge implications for the state's physicians, as approximately 23% of West Virginians are covered by Medicare, tying the state with Maine for the highest proportion of Medicare coverage nationally.<sup>7</sup>

Taken in total, Medicare and Medicaid patients account for a little more than half of West Virginia's insured population.<sup>8</sup> Any threat or change to one of those programs has major downstream consequences for West Virginia's physicians, and systemic threats and changes to both exist (e.g., MACRA, rapid expansion into and proliferation of Medicaid managed care organizations and state budgetary pressures). This calls for action and a clear path to changing the health care norm—namely transforming the payment mechanisms for health care delivery with public insurers.

## Narrative

The SIM grant State Health System Innovation Plan (SHSIP) provides a roadmap to help guide the state in this value-based transformation. Herein we summarize the most salient portions of the 324-page SHSIP that are relevant to physicians and other health care practitioners on the

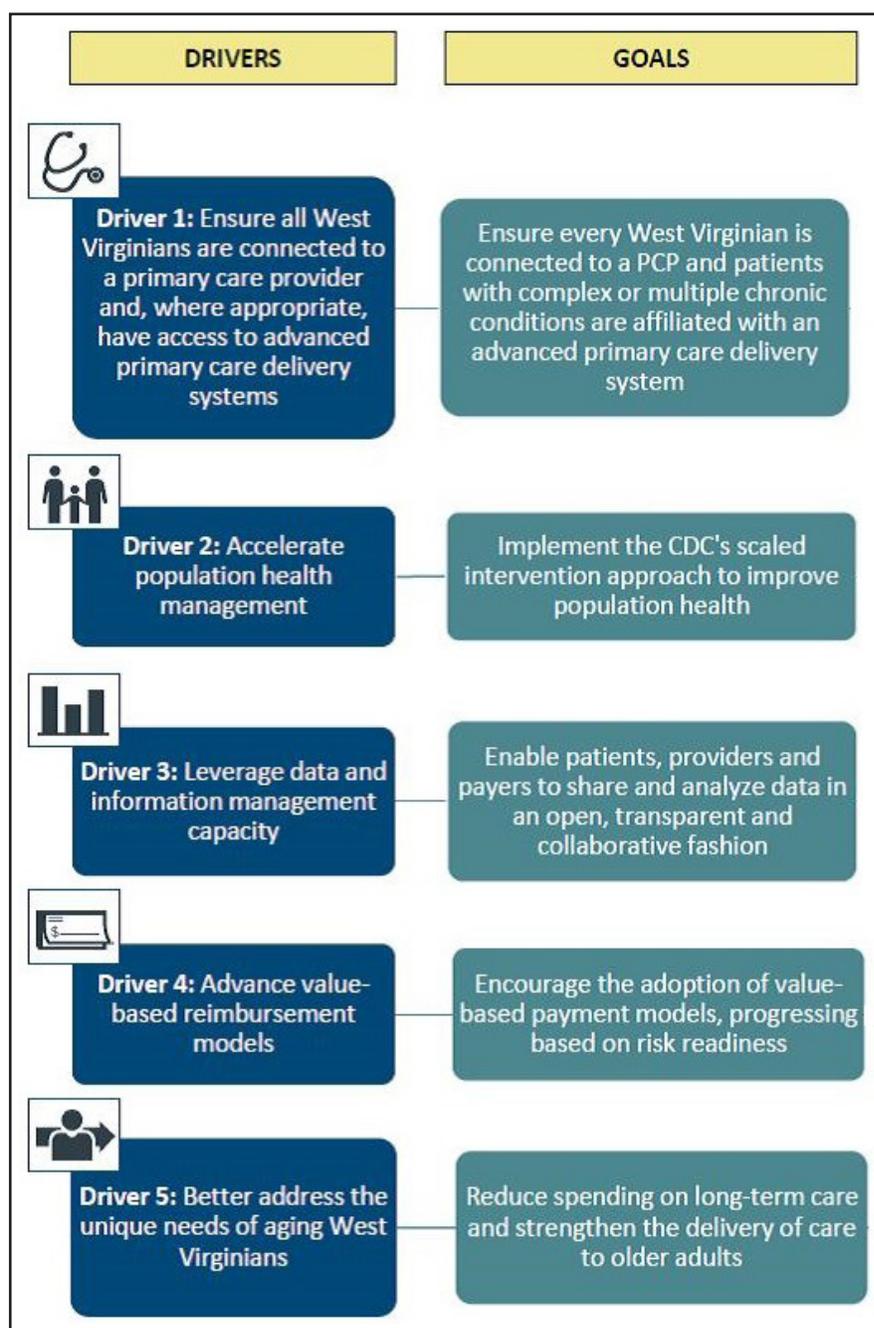
frontlines in the state. Through the CMS Innovation Center, the state of West Virginia received a SIM grant of \$1.9 million in February 2015 to develop a plan to transform the state's health care delivery and payment system. West Virginia Department of Health and Human Resources Cabinet Secretary Karen Bowling appointed a representative task force of insurers, providers and consumers to craft the SHSIP.<sup>9</sup> (p147) All authors of this article served on or participated in that task force.

The CMS Innovation Center expected states' SHSIPs to align their Medicaid programs with the general direction of the Medicare changes taking place at the federal level, particularly concerning the adoption and growth of APMs. The CMS Innovation Center encouraged the involvement of private and commercial insurers. West Virginia's SHSIP planning process included all authorized Medicaid managed care organizations for state fiscal year 2016, the Public Employees Insurance Agency, the West Virginia Children's Health Insurance Program, Highmark Blue Cross Blue Shield of West Virginia and Humana, Inc.

The SHSIP focuses on five key drivers necessary to transform West Virginia's health care delivery and payment system. These drivers are detailed in Figure 1. This article showcases two related SHSIP priorities most relevant to physicians: 1) increasing primary care provider affiliation and 2) developing and expanding programs to address the needs of health care super-utilizers. The overall SHSIP implementation strategy of creating a public-private partnership to help coordinate the state's limited health care resources and implement the SHSIP is also discussed.

#### *The Importance of the Primary Care Provider*

Driver 1 illustrates the importance of a patient establishing and



**Figure 1. Above is an excerpt from the larger SHSIP driver diagram. These five drivers and associated goals form the key priorities for health care delivery and payment transformation in the SHSIP.<sup>9</sup> (p93)**

maintaining a relationship with a primary care provider. Based on Centers for Disease Control and Prevention data, 21.3% of West Virginians do not have a usual place to receive medical care.<sup>10</sup> For a sizable portion of West Virginians—

given the state's poor population health status—the need is greater than simply a place to access medical care. Advanced primary care delivery systems such as the patient-centered medical home or the Medicaid equivalent, the health



home, will be required to treat the complex needs and multiple chronic conditions of patients.

The SHSIP calls for the creation of a task force to consider patient attribution issues and refine the means of identifying and attaching patients without a primary care provider or an advanced primary care delivery system. This task force will be charged with developing standards and criteria for meeting the needs of high-acuity patients who require an advanced primary care delivery system. Subsequently, the SHSIP envisions that the task force will work with the state to recommend expanding the West Virginia Higher Education Policy Commission's Rural Health Initiative and the Bureau for Public Health's State Loan Repayment Program to recruit and retain more primary care physicians, especially in underserved and rural areas.<sup>9 (p306)</sup>

#### *Focusing on Super-Utilizers*

A long-term strategy of driver 2, which is closely linked to driver 1, is to concentrate on projects/programs to address super-utilizers. The overarching strategy is to deliver care in the most cost-effective, personalized setting possible and prevent unnecessary emergency department visits. The SHSIP defines super-utilizers as "patients who experience complex physical,

behavioral and social determinants of health that are not well met through the current fragmented health care system. These patients would receive better care at a lower cost if they were identified and provided coordinated care."<sup>9 (p102)</sup> West Virginia has several existing super-utilizer projects and has the opportunity to pursue a different type of intervention using paramedics because of recent rule changes.

#### *National Governors Association Super-Utilizer Initiative*

In parallel with the SIM grant, West Virginia joined a super-utilizer initiative through the National Governors Association. The state and its four largest health care systems—Charleston Area Medical Center, Cabell Huntington Hospital/ Marshall Health, Partners In Health Network and West Virginia University Health System—are participating and learning jointly with the states of Alaska, Colorado, Connecticut, Kentucky, Michigan, Rhode Island, Wisconsin and Wyoming. The initiative involves collaboration with insurers, health care providers and community organizations. The lessons learned and successful interventions stemming from these projects will be shared and hopefully brought to scale in the state.<sup>9 (p103)</sup>

#### *Community Paramedicine: A Different Type of Intervention*

During the 2016 West Virginia legislative session, a rule was approved to allow the director of the Bureau for Public Health Office of Emergency Medical Services (OEMS) to authorize community paramedicine demonstration projects.<sup>11</sup> The OEMS director can authorize demonstrations that utilize emergency medical service personnel, specifically paramedics, to perform episodic patient evaluation, advice and care aimed at preventing or improving a particular medical condition. All services provided by the paramedic that are outside normal emergency response and transport roles must be under the direction of a physician. The goal of these demonstrations is twofold: 1) to reduce unnecessary use of emergency department services and 2) to enhance access to primary care for underserved and rural populations.

#### *West Virginia Health Transformation Accelerator (WVHTA)*

The question of who will implement the relevant recommendations of the SHSIP loomed large with the SIM task force. Ultimately, the task force called for the creation of a private, independent non-profit organization tasked with coordinating the state's limited health care resources and implementing the SHSIP recommendations in partnership with the state. This entity, the WVHTA, is proposed as a catalyst for improving the health of West Virginians by building statewide collaboration. The WVHTA is currently in its formation phase, but it is anticipated that the state's health insurers, large health systems and grant makers will assist in funding the entity—with additional money coming from securing federal grants and other funding opportunities. At this time, it is doubtful that any state funding will support the WVHTA.

The rationale for the WVHTA was articulated well by Cabinet

Secretary Bowling: “Our state, similar to other SIM states, recognizes the challenges of organizing resources to rapidly and dramatically transform our health care system to value-focused. Still, we know that the status quo is unsustainable and we must pursue value in our health care system by striving to achieve the Triple Aim.”<sup>9 (p0)</sup> The physician community has a vital role in ensuring the WVHTA’s success—both by supporting its mission, accessing it for resources and collaborating with it on relevant projects, including those detailed in this article.

## Conclusion

West Virginia’s public insurance-based health care system is beset with multiple internal and external forces, including state governmental budgetary deficits, poor population health status and federal legislative changes, such as MACRA, that make a fee-for-service system unsustainable. These forces make the shift to a value-based system a necessary yet complicated and labor intensive endeavor. However, with the oft-cited statistic that one-third or more of health care services can be classified as wasteful, there is a

considerable amount of overhead in the system that can be removed and appropriately reallocated without sacrificing patient care and the financial bottom line.<sup>12</sup> As an integral part of the health care system, physicians will be essential partners in designing the value-based delivery and payment models of the future. The SHSIP, with support of the WVHTA, is a reasonable plan for navigating into the future.

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To download the SHSIP and access all SIM-related materials, please visit:

<http://www.wvhicollaborative.wv.gov/Pages/WV-SIM-Grant.aspx>.

## PHYSICIANS NEEDED (OUTPATIENT EXAMS – NO TREATMENT)

Tri-State Occupational Medicine, Inc. (TSOM) is looking for physicians to join their group to perform disability evaluations in their WV offices. Part-time and possible full-time opportunities. No treatment is recommended or performed. No call, no weekends and no emergencies. Physicians working for us have various backgrounds and training. Training and all administrative needs including scheduling, transcription, assisting, and billing are provided. Some travel is required. Must have a current WV medical license. TSOM has an excellent reputation for providing Consultative Evaluations for numerous state disability offices. Contact: Susan Gladys 866-929-8766 / 866-712-5202 (fax) / [susang@tsom.com](mailto:susang@tsom.com).

