NATIONAL ASSOCIATION OF CHRONIC DISEASE DIRECTORS
Promoting Health. Preventing Disease.

GEAR Group 3 – Understanding Healthcare Payment Reform

Matrix of Payment Reform Activities in GEAR Group States

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The United States healthcare system is changing rapidly, placing greater emphasis on primary care and transitioning from an acute care model to comprehensive chronic disease management, which can and should include integration with public health. The National Payment Reform Initiatives – Related to Chronic Disease Prevention Matrix is intended as a resource for public health practitioners interested in understanding specific national payment reform initiatives and how some state chronic disease prevention programs have been involved in these initiatives. The 2016 GEAR Group focused on Understanding Healthcare Payment Reform created this matrix to facilitate cross-learning between health departments and the sharing of new ideas. It can also be used as a tool for orienting public health professionals new to working with healthcare systems.

	National Payment Reform Initiatives – Related to Chronic Disease Prevention				
	Center for Medicare and Medicaid Innovation (CMMI)				
	Transforming Clinical Practice Initiative (TCPI)	Medicaid Innovation Accelerator Program	1115 Waivers (including Delivery System Reform Incentive Payment Program (DSRIP))	State Innovation Model	Medicaid Expansion
Arkansas Completed by: Appathurai Balamurugan, MD MPH State Chronic Disease Director Email: Appathurai.balamurugan@arkansas.gov	MidSouth PTN was funded as a Practice Transformation Network, serving Arkansas, Tennessee, and Mississippi. The network aims to engage 34 academic and community hospitals, over 330 small and large primary care and specialty practices with over 4,300 clinicians reaching over 3 million patients. The network will leverage current and planned informatics	N/A	Arkansas Works is an innovative program that aims to strengthen the State's individual premium assistance model, while also instituting reforms to encourage employer-based insurance, incentivize work and work opportunities, promote personal responsibility, and enhance program integrity. Arkansas plans to extend its 1115 waiver demonstration	Arkansas received a SIM grant in Round 2. As part of the SIM grant, Arkansas was required to develop a 'Population Health Plan' working along with the Arkansas Department of Health. While this is a great first step for Primary Care-Public Health integration, there was no funding attached to the 'Population Health Plan'.	Arkansas is a Medicaid expansion state. Arkansas chose a unique model of expansion called 'Health Care Independence Program' (aka 'Private option'). Arkansas uses federal Medicaid expansion monies to purchase private insurance for those who meet the eligibility criteria. Approximately 300,000 Arkansans are covered through this program. The program will

	capacity, prior experience in training and performing quality improvement, and community/stakeholder engagement. The network will also rely on an array of informatics tools that have been developed at Vanderbilt to enhance collection and management of clinical data, provide clinical decision support, and collect patient reported data. There are a number of initiatives at the state level that facilitate transformation of clinical practice: 1. Arkansas Health Care Payment Improvement initiative 2. EHR incentive payment program 3. Arkansas Clinical Transformation (ACT) program		through December 31, 2021, with the following changes: • Implementing a premium assistance program for employer-sponsored insurance. • Instituting premiums for Arkansas Works beneficiaries with incomes above 100% of the federal poverty level and terminating Independence Accounts. • Incentivizing timely premium payment and completion of healthy behaviors. • Eliminating retroactive coverage. • Instituting procedures for expeditious termination of the waiver. • Providing for work referrals.		expire at the end of 2016, but will continue under a new name, 'Arkansas Works', with some key changes to the program.

	Arkansas Department of Health Chronic Disease Branch participates in some of these initiatives.				
Indiana Completed by: Brenda Jagatic BScN RN CDE Diabetes Education Coordinator Indiana State Department of Health (ISDH) Email: bjagatic@isdh.in.gov Who is involved in the INPCLC? 1.Ann Alley Director, ISDH 2.Brent Anderson, Practice Coach, ISDH banderson@isdh.in.gov 3.Nicole Coton	Great Lakes PTN is funded to serve as Practice Transformation Network. Working across Indiana, Illinois and Michigan, the network aims to engage 11,500 clinicians through learning practices capable of providing better health and improved care at a lower cost for a population of more than 10 million Americans. The network will train and deploy 52 quality improvement advisors to coach clinicians through the five phases of patient-centric practice transformation, provide direct technical assistance in meaningful use, Physician Quality Reporting System, and local quality improvement efforts to help prepare	With regard to Medicaid beneficiaries who receive long-term services and support (LTSS), the Innovation Accelerator program (IAP) is offering program support to states in two distinct areas: 1. Housing-Related Services & Partnerships 2. Incentivizing Quality & Outcomes (IQO) in community-based LTSS programs. Indiana became involved in a 6-month project in April 2016 that provides states with strategic planning support in developing an IQO approach for community-based LTSS.	Healthy Indiana Plan (HIP) 2.0 was an 1115 waiver to allow Medicaid expansion outside the usual route. Other waivers: Plan to integrate behavioral health into primary care. An exception to the Medicaid rule “a Medicaid beneficiary cannot receive two services on the same day” - permitting behavioral health and medical appointment of the same day.	N/A	Indiana was 1 of 6 states that expanded Medicaid using waivers that gave it additional flexibility in designing expansions. The most notable features of the Healthy Indiana Plan (HIP) 2.0 are “POWER Accounts” modeled on health savings accounts, a delay in the effective date of coverage until income-based premiums are paid, and a rule that locks some beneficiaries out of coverage if they don’t pay their premiums. HIP 2.0 has multiple parts, including 4 different Medicaid benefit packages and it requires administering and tracking elements, such as premium payments or co-payments, compliance with

Health Systems Epidemiologist, ISDH ncoton@ishdh.in.gov 4.Lindsey Sanner Chronic Disease Evaluator, ISDH lsanner@isdh.in.gov Other resources: Mike Hindmarsh (MH), Centre for Collaboration, Motivation, & Innovation www.centreCMI.ca info@centreCMI.ca *The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement.* IHI Innovation Series white paper. Boston: Institute for Healthcare Improvement; 2003.	clinicians for participation in value-based payment systems. The 1305 CDC grant (Domain 3 Health Systems Intervention) provided funding for the Indiana Primary Care Learning Collaborative (INPCLC) which was ISDH's homegrown TCPI to address the need to transform health care to better meet the needs of people with/at risk for chronic conditions by increasing implementation of both quality improvement processes and team-based care. Goal of INPCLC: transform care delivery and improve population health at the health care system & community levels. Four domains of this initiative: 1.Epidemiology & Surveillance 2.Environmental approaches 3.Health system interventions				healthy behaviors, health savings account balances & rollover funds, presumptive eligibility determinations, and services that would have been covered retroactively for certain groups. HIP 2.0 is a demonstration project to test the impact of premiums on enrollment and utilization of services. Through HIP 2.0 the number of Medicaid participants in Indiana was increased by 300,000.

	4. Strategies to improve community-clinical linkages. State-funded CHCs, FQHCs, and RHCs in the collaborative: 1.Attended 3 learning sessions 2-3 months apart 2.Between sessions teams were required to work on a PDSA(s) 3. At subsequent sessions, teams reported on the status of their PDSAs to ISDH and each other 4. Participants reported monthly quality measures. 5.Outcomes Congress: final outcomes report out by teams Conclusion: Centers completed a public final report out for ISDH and a general audience on successes, challenges, and key learning (i.e. teams valued “peer to peer” sharing). Results: teams improved 20 of 21 quality measures over a 12				

	month period by an average of 13.8%.				
Nevada Completed by: Vickie Ives, MA Integrated Health Systems Manager, Chronic Disease Prevention and Health Promotion, Nevada Division of Public and Behavioral Health Email: vives@health.nv.gov	N/A	N/A	Nevada does not at this time have 1115 waivers that involve the Chronic Disease Prevention and Health Promotion Section of the Division of Public and Behavioral Health. There has been ongoing interest in exploring this as a possibility in trying to establish a route to reimbursement for Community Health Workers, and stakeholder partners are currently discussing if this is a path to attempt to pursue toward that end.	Nevada was awarded a Phase 1 SIM Planning Grant. Even though funding was not attached in relation to the SIM grant, the planning process included the Chronic Disease Prevention and Health Promotion Section on multiple fronts. Meetings with state Medicaid partners and materials provided by the Section included promising opportunities for collaboration relating to the Diabetes, Community Health Worker, Heart and Stroke, and Tobacco programs for possible future collaboration.	Nevada is a Medicaid expansion state, and has had one of the largest percentage increases in enrolled Medicaid beneficiaries of the states participating. Analysis of the impact of the expansion on health outcomes is an area of active exploration within the Section.
North Carolina Completed by: Joyce Wood, BS, MBA Operations Manager	The NC Division of Public Health partners with Community Care of North Carolina (CCNC). Through a public-private partnership,	N/A	Waiver submitted 6/1/16. In September 2015, the North Carolina General Assembly enacted Session Law (SL) 2015-245	N/A	N/A

Chronic Disease and Injury Section, NC Division of Public Health Email: Joyce.Wood@dhhs.nc.gov	CCNC has brought together regional networks of physicians, nurses, pharmacists, hospitals, health departments, social service agencies and other community organizations. These professionals work together to provide cooperative, coordinated care through the Medical Home model. CCNC's activities under the PTN grant include: • Preparing practices for value-based reimbursement • Leveraging the power of informatics • Helping providers deliver "whole person care" • Clinical pharmacy integration and improved medication management		(Appendix A), to transform and reorganize North Carolina's Medicaid and NC Health Choice programs. This legislation directed DHHS to redesign Medicaid and NC Health Choice to achieve the following goals: 1) Ensure budget predictability through shared risk and accountability; 2) Ensure balanced quality, patient satisfaction and financial measures; 3) Ensure efficient and cost -effective administrative systems and structures; and 4) Ensure a sustainable delivery system through the establishment of two types of Prepaid health plans: provider -led entities and commercial plans. The plan submitted is designed to improve health care access, quality and cost efficiency for the growing population of Medicaid and NC Health		

	According to an independent evaluation by leading actuarial firm Milliman, Inc, CCNC saved nearly a billion dollars in the four years from 2007 through 2010.		Choice beneficiaries. Care delivery will use accountable, next generation prepaid health plans. Payments will reward value and outcomes rather than volume.		
Utah Completed by: Teresa Roark, MPH Health Program Coordinator Healthy Living through Environment Policy and Improved Clinical Care (EPICC) Program Email: troark@utah.gov	N/A	N/A	N/A	Utah has a "Model Design Award". This is our second "Model Design Award". Project focuses on developing three "use cases": behavioral health integration, obesity/diabetes, and advanced care planning and 7 areas of cross cutting infrastructure: Health Information Technology, Value Based Purchasing, Healthcare Delivery Transformation, Quality Measurers, Workforce Planning, Regulations, and Stakeholder Engagement. The SHD Bureau of Health Promotion has collaborated most closely in the development of the use case	Utah has not expanded Medicaid. SHD Director has been very involved in working with legislature and governor to develop feasible proposals. Some SHD Bureau of Health Promotion staff have worked with local health policy organizations to educate internal and external partners on issues around insurance gap, has not been a major part of work. Players include SHD executive leadership, elected officials, professional organizations (UMA), health policy orgs, and others.

				for diabetes/obesity. In addition, we have been involved in an effort around "Quality Measurers" to explore the possibility of sharing clinical data between a large healthcare system and the SHD. This initiative is coordinated by the state health department. Other key partners include: University Biomedical Informatics Program, State HIE, Medical Education Council, Commission on Aging, QIN, Pediatric Quality Improvement Org, University Social Research Institute, Leaders for Health Coalition, Telehealth Network, and Dept. of Human Services.	
West Virginia	VHQC was awarded as a Practice Transformation	WV applied for funding for the Accountable Health	N/A	WV received a second round SIM design grant in February	West Virginia opted to expand Medicaid under ACA starting on

Completed by: Jessica Wright RN MPH Director, Division of Health Promotion and Chronic Disease, WV Bureau for Public Health Email: Jessica.G.Wright@wv.gov	Network serving multiple states including West Virginia. The network aims to engage 1,250 primary care clinicians, with the goal of improving care for more than one million patients. The network will provide on-site technical assistance to improve quality measures, use data to drive improvement, and build a value-based medical neighborhood. Community Care of WV, an FQHC system, was recently recognized by CMS as an exemplar high-performing practice in its newly launched Transforming Clinical Practice Initiative and is contributing to the development of the national change package for the initiative. WV clinicians (as a whole) are not explicitly covered in any of the Practice Transformation Networks established under	Communities funding opportunity (CMMS) using strategies based on the WV SIM/SHIP Plan that links community-based health and social support resources to the health care delivery system. WV has several ongoing and promising community health worker pilots and demonstrations. Williamson Health and Wellness Center, an FQHC, in partnership with Marshall University and Duke University, received a CMS Innovation Center Health Care Innovation Awards grant to deploy a community health worker model to serve patients with uncontrolled diabetes in southern WV. The project received additional funding from the U.S. Health Resources and Services Administration (HRSA) to expand the model to address		2015. The state submitted its design plan to CMMI on July 21, 2016. The plan is available here: http://www.wvhicollaborative.wv.gov/Pages/WV-SIM-Grant.aspx	January 1, 2014. Since 1996, West Virginia has operated under a 1915(b) Medicaid Managed Care Waiver that permits it to enroll beneficiaries in managed care. The state decided to enroll its Medicaid expansion population into managed care on July 1, 2015. As of March 2016, four MCOs serve West Virginia's Medicaid beneficiaries. Medicaid insures approximately 521,000 West Virginians, of which 150,000 are in traditional fee-for-service (about 29%) and 371,244 (about 71%) in Medicaid managed care.

	the TCPI effort recently launched by CMS.	other chronic conditions. A coalition of health care providers also secured private foundation funding to deploy the model in their service catchment area in West Virginia's Mid-Ohio River Valley.			