



Promising State Innovation Model Approaches for High-Priority Medicaid Populations: Three State Case Studies

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INTRODUCTION

The State Innovation Models (SIM) initiative within the Center for Medicare and Medicaid Innovation (CMMI) is partnering with states to advance multi-payer health care payment and delivery system reform models. Each state-led model aims to achieve better quality of care, lower costs, and improved population health and to shift the reimbursement landscape to reward providers for quality outcomes rather than volume. Through Design and Test cooperative agreements, CMMI has provided support to 34 states, three territories, and the District of Columbia to develop and implement broad-scale multi-payer delivery system and payment reform models. Each SIM awardee has been required to use strategies to develop or enhance the effectiveness of models, such as health information technology (HIT), workforce development, consumer engagement activities, and integration with public health programs. Awardees are also required to use policy levers to promote adoption of the models.¹

States participating in the SIM initiative have focused most of their efforts on testing large-scale, statewide health care delivery and payment reforms, including episode of care models, patient-centered medical homes, Medicaid accountable care organizations, and accountable communities for health. Yet many states are also designing and testing smaller, more focused initiatives and reforms that often fall under the radar—generally because of their limited size and scope. In some cases, these initiatives are pilot projects that

are being tested and refined; in other cases, they are focused on a defined population with a particular need. These reforms, however, can be every bit as innovative as a state's "big ticket" items and can serve as valuable models for states looking to improve a particular aspect of their health systems. This brief describes three promising, smaller-scale SIM initiatives:

- **Massachusetts Child Psychiatry Access Program (MCPAP)** supports the integration of physical and behavioral health services for children in need by giving pediatric primary care providers access to psychiatric consultation services. Expanded under SIM, MCPAP for Moms provides support to primary care providers serving pregnant and postpartum women and their children, helping them to effectively prevent, identify, and manage depression.
- **Tennessee's Quality Improvement in Long-Term Services and Supports (QuILTSS)** initiative is a multi-pronged strategy focused on: 1) quality- and acuity-based payment for nursing home facilities, including enhanced respiratory care; 2) value-based payment and delivery system reforms for home- and community-based services for seniors, adults with physical disabilities, and individuals with intellectual and developmental disabilities (I/DD); and 3) a comprehensive workforce development program and strategy designed to increase the quality, competency, and supply of direct support workers to improve member experiences across long-term services and supports (LTSS).
- **Ohio's Opioid Performance Measures** were developed and incorporated into several episodes of care within the

state's SIM work. By building quality measures to monitor appropriate opioid prescribing, Ohio aims to leverage its payment and delivery system transformation efforts to further its response to the serious and growing opioid overdose crisis across the state.

MASSACHUSETTS CHILD PSYCHIATRY ACCESS PROGRAM

Background

The Massachusetts Child Psychiatry Access Program (MCPAP) works to increase children's access to behavioral health treatment by connecting primary care providers (PCPs) and pediatricians directly with children's mental health teams for psychiatric consultations and referrals and by educating PCPs on managing mild to moderate behavioral health disorders in primary care. MCPAP began as a pilot program in 2003 at the University of Massachusetts Medical School to address the Commonwealth's shortage of child psychiatrists and to better integrate behavioral health services into primary care settings. A 2002 report detailing Massachusetts families' experiences with the pediatric behavioral health system found that 33 percent of families waited more than a year for an appointment with a child mental health provider, and 77 percent reported that their pediatrician was not helpful in connecting them to resources.² MCPAP was implemented as a statewide program in 2004. It is currently funded by the Department of Mental Health (DMH) through a legislative budget appropriation.

Massachusetts used its SIM award to improve overall MCPAP program operations and to expand the program to a new target population: providers serving pregnant and postpartum women with behavioral health conditions. This new effort, MCPAP for Moms, provides psychiatric consultation support and education to obstetric providers, PCPs, and psychiatrists treating women with perinatal and/or postpartum behavioral health conditions. MCPAP for Moms was launched in 2014 and has grown considerably thanks to SIM funding.

Program Design

MCPAP provides free telephonic psychiatry consultations and specialized resource and referral support to PCPs that enroll in the program; currently, 3,674 pediatric primary care providers across the state are enrolled.³ The program is comprised of three regional consultation teams located at academic medical centers throughout the Commonwealth. Regional MCPAP teams consist of child psychiatrists, licensed therapists, resource and referral specialists, and program coordinators. The child psychiatrists and therapists provide telephone consultations to PCPs or on-site behavioral health clinicians (often offering advice or answering questions), as well as some face-to-face consultations. The resource and referral coordinators help providers connect families to services and supports. Teams are available for consultations Monday

through Friday, 9 am to 5 pm, and will respond to a call within 30 minutes.⁴

MCPAP for Moms assists obstetricians and other front-line providers in addressing pregnant and postpartum patients' mental health and substance use concerns. The program has three core components: 1) trainings and toolkits for providers and their staff on evidence-based guidelines; 2) real-time psychiatric consultation and referral; and 3) linkages with community-based resources.⁵ A key component of the psychiatric consultations is providing guidance on psychiatric medication management, as well as informing providers about medication alternatives and additional supportive services. Although the program was initially intended to support obstetric clinicians, around 20 percent of MCPAP for Moms users are psychiatrists themselves, who report uneasiness about prescribing to pregnant or breastfeeding women.⁶

Alignment with SIM Vision

Two core goals of Massachusetts' accountable care strategy—which the state developed during its participation in SIM—are establishing partnerships across the care continuum and integrating behavioral health and primary care. The MCPAP and MCPAP for Moms programs work to address both of these aims by connecting clinicians from different health care specialties to ensure that primary care and behavioral health services are integrated and providers are working together to address patients' physical and behavioral health needs.

SIM funding supported the following MCPAP activities to promote provider partnerships and behavioral health-primary care integration:

- Full-time access to MCPAP service for all enrolled PCPs in the Commonwealth;
- A strategic assessment of the MCPAP program to determine the most effective staffing model for the service, especially in the context of broader payment reform;
- An analysis of trends in pediatric psychotropic prescribing;
- A statewide screening, brief intervention, and referral to treatment training for providers focused on addressing adolescent substance use; and
- The scale-up of MCPAP for Moms to serve all obstetric providers statewide.

Successes and Challenges

MCPAP

The MCPAP program had a number of notable successes during the state's participation in the SIM initiative, including obtaining sustainable funding for the program ahead of schedule through a full state appropriation, which has enabled the SIM team to reallocate funding originally set aside for MCPAP program operations to instead scale MCPAP for Moms. Another notable achievement was the significant increase in practice and provider utilization of the program. From 2014 to 2017, practice utilization increased from 71 percent to 78 percent, and provider utilization increased from

41 percent to 48 percent. At the same time, MCPAP teams improved their ability to respond to calls in 30 minutes or fewer. By 2017, 95 percent of all calls were answered in 30 minutes, compared to 89 percent at the start of the SIM initiative.⁷

A consistent challenge for MCPAP has been making the case to PCPs that children's mild to moderate behavioral health needs can be adequately addressed in the primary care setting through consultation and support. Another challenge has been maintaining provider utilization of the service. After determining that some practices decreased their use of MCPAP over time, the Commonwealth conducted an outreach initiative to better understand the decrease, finding that some practices stopped using MCPAP after hiring new onsite behavioral health staff. Finally, the state also noted considerable regional variation in MCPAP utilization and, as a result, is working to identify areas for quality improvement.⁸

MCPAP for Moms

The MCPAP for Moms program successfully transitioned from a pilot program to a fully operational statewide service with SIM funding. By 2017, 118 obstetric practices in the state had enrolled (59 percent of eligible practices), far exceeding the target of enrolling 99 practices by the end of the SIM grant. Seventy-five percent of enrolled practices and 38 percent of enrolled providers utilized MCPAP for Moms at least once between 2016 and 2017.⁹ MCPAP did see a drop in the percentage of practices using the service in 2017 but was able to attribute that drop to the enrollment of a large group of "late adopter" practices in the last quarter of year, which were less likely than previously enrolled practices to use the program.¹⁰

Future Plans

With a secured source of ongoing funding, DMH plans to sustain both MCPAP and MCPAP for Moms as statewide programs following the conclusion of the SIM initiative. Program staff are seeking to determine how the Commonwealth's new Medicaid accountable care organization (ACO) model may impact the need for—and use of—MCPAP and MCPAP for Moms. Massachusetts' Medicaid ACO model promotes the delivery of behavioral health care in more integrated settings, so pediatric primary care providers affiliated with an ACO may have access to new or additional behavioral health supports, thus reducing the need for MCPAP services. On the other hand, Massachusetts still faces a shortage of child psychiatrists, so many pediatric primary care providers may continue to rely on MCPAP for psychiatric consultations. DMH staff will work with the state's Medicaid ACOs to better understand how MCPAP and MCPAP for Moms fit under the new payment and care delivery models. In 2017, DMH took a first step by making some programmatic modifications to MCPAP to adjust to the Commonwealth's changing health care environment, including: moving from six regional hubs to three; shifting responsibility for care coordination to practices; and affiliating with ACOs and other networks of care.¹¹

TENNESSEE'S QUALITY IMPROVEMENT IN LONG-TERM SERVICES AND SUPPORTS (QuILTSS)

In 2013, Tennessee Governor Bill Haslam launched the state's Health Care Innovation Initiative, which was designed to transition reimbursement away from fee-for-service, reward health care providers for high-quality and efficient treatment of medical conditions, and help maintain people's health over time. Although Tennessee had achieved some success reforming long-term care and aligning health plan payments with state goals to expand access to home- and community-based services (HCBS) and aide system balancing through the TennCare CHOICES program,¹² little had been done to drive LTSS payment reform at the provider level. Payment and service delivery within nursing facilities remained cost-based, and quality performance was not uniformly recognized or rewarded across facilities. Similarly, payments to HCBS were largely fee-for-service and not linked to valued outcomes, due in part to the lack of uniform quality measures. SIM has helped to propel LTSS system delivery reforms, putting into place a quality framework and payment strategies that are centered on rewarding providers who improve TennCare members' experience of care, achieve desired outcomes, and promote a person-centered care delivery model.

Program Design

Launched in 2014, Tennessee's Quality Improvement in Long-Term Services and Supports (QuILTSS) is a TennCare value-based purchasing initiative centered on delivering high-quality LTSS, with an explicit focus on the performance measures that are most important to people who receive LTSS and their families. The QuILTSS framework focuses on: 1) implementing a value-based reimbursement model for nursing facility (NF) services, including enhanced respiratory care; 2) value-based payment and delivery system reforms for HCBS for seniors and adults with physical, intellectual, and developmental disabilities; and 3) workforce development to improve training, quality, competency, and increase the supply of individuals serving the LTSS community. The QuILTSS initiative is an ongoing, iterative effort to improve LTSS care delivery, engaging stakeholders regularly to assess the quality measures and payment systems in place to improve care and outcomes.

Payment Reform: Nursing Facility Services

Under the QuILTSS initiative, Tennessee has transitioned toward value-based reimbursement, where payment to nursing facilities is based on residents' assessed levels of need and then adjusted for performance on measures as outlined in the QuILTSS Quality Framework.

Legislation passed in 2014 generated funds for the new nursing home reimbursement by modifying a long-standing

nursing home bed tax into a nursing home assessment fee. The new law included provisions for acuity- and quality-based payments, with 20 percent of the new funds generated by the nursing home fee designated for quality-based adjustments to facilities during the transition period to value-based reimbursement.¹³

The transition to value-based reimbursement has occurred in two phases. Phase One, which launched in early 2014, included a “bridge payment” whereby facilities were rewarded for meeting primarily process measures. The bridge payments were designed to reward facilities’ efforts toward implementing quality measurement and quality improvement activities, such as patient/family satisfaction surveys, actions to improve survey results, and making appropriate staffing adjustments—activities that would build their capacity for achieving desired outcomes. In order to be eligible for the quality payment portion of the reimbursement, a nursing facility had to meet a threshold level of performance.

In Phase Two, which launched July 1, 2018, a nursing facility’s reimbursement is based in significant part on its performance on specified quality measures. Quality measures include: satisfaction (i.e., resident satisfaction, family satisfaction, and employee satisfaction); culture change and quality of life (i.e., resident choice, respectful treatment, resident and family input, and meaningful activities); staffing/staff competency (i.e., RN hours per resident day, CNA hours per resident day, staff retention, consistent staff assignment, and staff training); and clinical performance (i.e., antipsychotic medication prescribing; urinary tract infection prevention).

TennCare developed a point system to determine the quality payment a nursing facility may receive. Nursing facilities receive points for their performance on each quality measure. For the quality incentive portion of the rate, the total number of points the facility receives is then divided by the maximum number of points possible to determine the percentage of the quality incentive pool the facility will be paid. In 2018, rules were finalized to implement the prospective payment system, with the expectation that NF reimbursement will move fully to an outcome-based methodology by 2020. Threshold and quality measures, categories, definitions, benchmarks, and point values will be adjusted over time (with input from stakeholders) based on experience, system-wide performance, and priorities.

Value-Based Purchasing Initiative for Enhanced Respiratory Care

Also part of QuILTSS is a quality improvement effort designed to leverage value-based payment to help drive improved quality and outcomes for individuals in nursing homes with enhanced respiratory care needs—i.e., individuals who are ventilator dependent or require suctioning through a tracheostomy. Faced with a tenfold increase (941 percent) in enhanced respiratory care (ERC) services between 2011 and

2015 (from \$2.2 million to \$22.8 million), TennCare in 2016 revised its reimbursement structure for ERC services provided in nursing facilities. The new structure focuses on moving individuals off respirators (a.k.a. liberation) as well as other measures that maximize independence and quality of life.¹⁴ Reimbursement rates are established for each facility based on the facility’s performance on key performance measures, including rates of liberation, decannulation (process whereby a tracheostomy tube is removed), infection, unplanned hospitalization, and use of advanced technology to improve quality of care and life. This shift to quality-based reimbursement is part of a larger strategy to improve the quality and efficiency of ERC services. To date, evaluation results on the ERC initiative have proved promising. Payments to nursing homes for complex respiratory care were reduced by 25 percent in the first year of the new payment approach, with 13 percent more people weaned from the ventilator and improved use of technology to reduce infections, hospitalizations, and deaths.

Value-Based Purchasing Initiatives for Home- and Community-Based Services

As part of the QuILTSS initiative, TennCare is also leveraging value-based payment strategies across its HCBS programs to drive improved quality and person-centered outcomes.

Value-based payment approaches were embedded as part of the launch of the Employment and Community First CHOICES program, the state’s recently implemented managed LTSS program that integrates physical, behavioral, and LTSS services for the I/DD population and is designed to help individuals with I/DD achieve employment in integrated settings, earn a competitive wage, and live as independently as possible, fully participating in community life. Employment services reimbursement is contingent upon providers reaching a series of deliverables and employment outcomes based on beneficiaries’ identified needs.¹⁵ Expected outcomes include: developing a job profile that meets the requirements of Vocational Rehabilitation agencies; creating a job plan that meets certain standards; getting hired; and remaining employed for a series of months. Value-based payment strategies include outcome-based reimbursement for up-front services leading to employment; tiered outcome-based reimbursement for Job Development and Self-Employment Start-Up based on the member’s “acuity” level and paid in phases to support tenure; and tiered reimbursement for Job Coaching also based on the member’s acuity but taking into account the length of time the person has held the job and the amount of paid support required as a percentage of hours worked (which helps to incentivize greater independence in the workplace, the development of natural supports, and the fading of paid supports over time).

After more than two years of success in using these payment approaches, TennCare is working with providers and stakeholders to implement similar approaches in its

longstanding Section 1915(c) waivers for individuals with intellectual disabilities. The changes will introduce pre-employment services with outcome-based reimbursement approaches that incentivize and reward best practice job coaching through a tiered and phased payment structure, similar to that used in Employment and Community First CHOICES. These amendments are designed to help move individuals toward employment and increased community integration, as well as to provide more flexibility for individuals served.

In early 2016, Tennessee implemented a new model of support for the delivery of behavioral crisis prevention, intervention, and stabilization services for the I/DD population. Delivered under TennCare, the service focuses on crisis prevention, in-home stabilization, sustained community living, and improved quality of life for individuals with challenging behaviors that place themselves and others at risk. The value-based reimbursement approach utilizes a monthly case rate aligned to support improvement and increased independence over time as the provider is successful in helping paid or unpaid caregivers increase their capacity to provide needed support in order to prevent and/or manage crises. Two analyses of claims-based data found substantial reductions in three broad categories: crisis respite, emergency department utilization, and psychiatric inpatient stays.

Tennessee's LTSS Workforce Strategy

As a central component of QuILTSS, Tennessee created a comprehensive LTSS workforce development program. This effort complements the state's value-based payment strategies for LTSS by aligning the opportunities for direct service worker training and degree attainment with LTSS quality measures, thereby rewarding providers that employ a well-trained workforce.¹⁶ When QuILTSS is fully implemented, staff training accounts for 25 percent of total quality points that may be earned by a NF provider for the quality-based component of its per diem rate. This staff training will also affect a provider's success across other measures, as providers employing better trained and qualified staff will be compensated at a higher rate.

Through an extensive stakeholder engagement process, TennCare found that individuals who use LTSS prioritize the need to have a well-trained, competent, and reliable workforce. The LTSS workforce development program provides: 1) targeted training to direct service workers who participate in TennCare; and 2) an educational initiative that creates a new career path for workers to earn credits for postsecondary certificates or degree programs.

The curriculum for the workforce development component of the program is being launched in 2019 through the state's community colleges and colleges of applied technology. The curriculum provides a career path for direct support workers and is designed to help individuals build competencies to attain more advanced jobs and higher wages. The program includes:

mentoring; coaching and career planning; and a state-developed registry that links participants together and tracks training and educational achievement.

Tennessee used SIM funds to support curriculum and infrastructure development and has created a business plan to support additional program components, including ongoing curriculum development that is translatable across different settings. The state has also created an online registry of direct support professionals.

Escalating direct service workforce challenges across HCBS programs has also led to the development of an alternative value-based payment approach in HCBS (in addition to the competency-based workforce development program). The new comprehensive approach to workforce development encompasses an array of provider capacity-building investments and workforce development incentives. Investments include engaging national subject matter experts at the University of Minnesota's Institute on Community Integration to assist in establishing processes for the collection and use of workforce-related data at provider and system levels to target and measure improvement efforts over time. Providers also received training and technical assistance to support adoption of evidence-based and best practices. Value-based payment strategies will then be implemented to incentivize providers to adopt practices that will lead to desired outcomes; these practices include data collection, reporting, and evidence-based approaches to workforce recruitment/retention, as well as culture/business model changes. Incentives will also be aligned at the worker level by implementing pass-through incentive payments to ensure that wages increase as workers increase their level of training and competency, as well as upon completing the certification program. Value-based payment approaches will transition to financial incentives for specific workforce and quality-of-life outcomes once best practices have been effectively adopted. The strategy will initially be implemented in Employment and Community First CHOICES, and ultimately Tennessee hopes to expand the approach across HCBS programs.

Success and Challenges

Tennessee has seen success in all three of its LTSS reform efforts. Under QuILTSS, the state's NFs have made significant strides in quality measurement and reporting practices, moving from 47th in the nation to 38th in the Centers for Medicare & Medicaid Services Five-Star Quality Rating System.¹⁷ Additionally, the ERC initiative produced significant cost savings, as well as improvements in the numbers of patients weaned off ventilation. TennCare has also seen increased consistency in quality improvement efforts across facilities (i.e., implementing processes), which has helped to lay the groundwork for quality-based outcomes reimbursement.

With respect to HCBS, value-based payment approaches are being used to drive increased employment outcomes and have been successful in reducing the use of crisis respite, emergency department utilization, and psychiatric inpatient

stays among individuals with I/DD who have challenging behavior support needs. It also holds great promise in offering a comprehensive strategy around what has become a national workforce crisis.

Under SIM, the state-developed Quality Application reporting system allowed TennCare to look at non-claims-based quality data from ERC providers on a quarterly basis (e.g., infection and death rates and use of advanced technology). While nursing facility-users had some initial difficulties, they have since transitioned to using the application with minimal problems. Tennessee provided in-person technical assistance to staff on use of the tool and has established a help desk to provide ongoing support. Users have given positive feedback on the system and say they appreciate the ability to see their scores without waiting until the end of the submission period.

Future Plans

Going forward, Tennessee will continue to expand on payment and delivery system reforms that most affect members' experience of care. TennCare sees QuILTSS initiatives as an evolving effort, and future efforts will be focused on further developing and refining the reimbursement models. TennCare sees value-based reimbursement as a powerful tool for achieving systems transformation and considers each of the models as the "new way of doing business."

OHIO'S OPIOIDS QUALITY MEASUREMENT

Background

Like much of the United States, the state of Ohio has been afflicted by opioid overdoses, which killed more than 4,300 people in Ohio and more than 42,200 people nationally in 2016.¹⁸ In many cases, those deaths are associated with prescription painkillers, such as oxycodone and hydrocodone, which health care providers commonly prescribe to patients for various types of pain; in other cases, those opioid overdose deaths are caused by heroin or other illicitly trafficked opioids.¹⁹ But deaths from legal and illegal opioids are closely related. Research has found approximately 80 percent of heroin users in treatment report that their opioid abuse began with prescription opioid painkillers.²⁰ Other research supports this, indicating that people addicted to opioids often began their addictions by misusing either their own prescription opioid painkillers or those obtained from family or friends.²¹ As knowledge of the risks of opioid painkillers has grown in recent years, Ohio has undertaken initiatives aimed at curbing the crisis, including the development of opioid-prescribing guidelines to encourage health care providers to follow best practices when deciding whether and how to prescribe opioid painkillers, and setting opioid-prescribing limits for patients with pain conditions.

Independent from, but complementary to, its work to intervene in the opioid crisis, the Ohio Governor's Office of Health Transformation has been working to transform its health care

payment and delivery systems under SIM. Using its SIM Model Design award, the state developed a plan for shifting to a value-based health care system and subsequently received a SIM Model Test award to implement the state's plan. Two major components of Ohio's SIM are to develop: 1) episodes of care (EOC) payments that reward health care providers for controlling costs and ensuring quality of care for defined "episodes," or courses of treatment for particular conditions (e.g., appendectomy, joint replacement, asthma); and 2) a patient-centered medical home (PCMH) model, called Comprehensive Primary Care (CPC), that emphasizes the role of primary care in delivering coordinated health care focused on patient needs.

Program Design and Incorporation into SIM Vision

In 2016, the Ohio SIM team made a connection between the opioid guideline development work in the state and its EOC design. While on track to design its next group of EOCs, members of Ohio's SIM team recognized that many of the episodes focused on procedures, such as spine and joint surgery, which they knew were associated with prescription opioid painkillers. From that realization, the state analyzed its Medicaid claims data and found that headache, low back pain, and orthopedic procedures (e.g., muscle sprains, ligament strains, bone fractures) represented a large share of opioid prescribing—conditions that overlapped with many of the planned EOCs. The state also found that opioid prescribing varied widely across providers for some procedures, suggesting room for improvement in adopting best practices for prescribing opioids. So Ohio pursued an opportunity to connect the state's response to the public health crisis of drug overdose deaths by promoting safer opioid prescribing with its SIM efforts to improve quality of health care as part of a shift to value-based payment.

Opioid Quality Measures

Ohio developed measures of appropriate opioid prescribing for its EOC payment model.

Measures tied to payment:

- Average difference in morphine-equivalent dose of opioids per day, 30 days pre-episode trigger and 30 days post-trigger

Measures not tied to payment:

- New opioids prescription fill rate

Source: Ohio Governor's Office of Health Transformation. "Dental tooth extraction: episode definition." 2017. Accessible at: <http://medicaid.ohio.gov/Portals/0/Providers/PaymentInnovation/DEF/Dental-Tooth-Extraction-Definition.pdf?ver=2017-12-21-111154-753>

In part because existing quality measures for appropriate opioid prescribing are limited (e.g., the National Quality Forum has endorsed only three measures)²² and also because the state had already conducted work to develop opioid-

prescribing guidelines, Ohio SIM program staff worked with a consultant to develop quality measures based on the state opioid-prescribing guidelines using morphine equivalent doses (MEDs). After designing draft opioid quality measures, the state sought feedback from providers on the measure specifications and plans for how to implement them. For example, providers commented on whether measure performance should be tracked and reported only for informational purposes or to inform provider payment. To determine whether a patient's use of opioids increased during the timeframe of the episodes, Ohio's SIM staff worked with a consultant to develop a measure of patients' morphine equivalent dose of opioids before and after an episode. This was important to providers because many patients already take opioids when they present for treatment. For example, a patient receiving spinal fusion surgery may already be prescribed opioids from another provider for back pain before having surgery, and the surgeon wants to ensure he or she is not penalized for the patient's existing opioid prescription. This pre- and post-episode measure design (rather than a post-episode-only measure) also addressed concerns that providers could have been penalized for treating patients who already had opioid prescriptions by limiting their responsibility to prescribing that was under their control.

As of summer 2018, Ohio incorporated measures of appropriate opioid prescribing into approximately a dozen EOCs. After identifying the opportunity to use EOCs as a strategy for improving opioid-prescribing practices, the state also developed an EOC that had not been planned previously—tooth extraction—because that episode accounted for a large amount of opioid prescriptions in its Medicaid program and because it allowed another type of provider (dentists) to participate in the initiative.

Applying the opioid-prescribing quality measures as part of a value-based payment model promoting best practices for prescribing. EOCs that incorporate opioid quality measures are being implemented first in a "reporting" phase in which providers are not paid based on their performance but receive reports with details on their performance. Later, when an episode is tied to financial incentives, providers will be rewarded for controlling costs while meeting quality targets or at risk for a penalty if their costs exceed thresholds. Once those EOCs are fully implemented, the quality measure on pre- and post-episode opioid use is planned to factor into financial incentives, while a second measure of new opioid prescriptions will remain an informational-only measure. The state will follow its established protocol for quality measure target-setting in EOCs, beginning by setting benchmarks that a large majority of providers are expected to meet in early performance periods (e.g., 75 percent achievement rates) and moving the target over time.

Successes and Challenges

Ohio encountered a number of successes and challenges in seeking to refine its EOC program to address the opioid overdose death crisis. Among the first challenges was a scarcity of quality measures for appropriate opioid prescribing. This stems in part from evolving ideas around the safety of opioids (i.e., that there is a greater risk of addiction than many providers believed until very recently), as well as because the concern about overuse of opioids is relatively recent.²³ However, Ohio succeeded in developing its own quality measures by: 1) leveraging its existing work to develop opioid-prescribing guidelines for providers; 2) analyzing the state's own Medicaid claims data to develop a state-specific understanding of opioid-prescribing patterns and opportunities for improvement; and 3) engaging providers in a stakeholder input process to determine whether the measures were reasonable and fair, to elicit their concerns, and to seek their feedback on how to improve use.

Ohio's SIM team also anticipated apprehension from providers about holding them accountable for reducing use of opioid prescriptions. A primary concern among providers was that they only be held accountable for care under the providers' influence. In response to provider input, the state developed a new measure aimed at more accurately measuring opioid use that is under the influence of providers responsible for an EOC. Although the state is still in the midst of implementing its measures and may still face concerns from providers, they believe their approach of seeking stakeholder input from providers and their work to monitor opioid use that is within the control of providers responsible for episodes may help to alleviate those concerns. Ohio's SIM team is optimistic its approach to use health care payment and delivery system reform to tackle public health challenges could serve as a model for addressing other public health issues.

Future Plans

In addition to transitioning its EOCs with opioid quality measures from a reporting phase to full implementation with financial incentives, Ohio has future plans to begin incorporating its opioid quality measures into its CPC program, the other major component of the state's SIM. Under the state's approach to payment and delivery system reform, its PCMH program is built with the understanding that primary care providers have the potential for influence over the quality and cost of care delivered to their patients. CPC practices receive per-member per-month payments to support activities such as same-day access to care, and they are held accountable for coordinating patients' total cost of care and quality of care through a shared-savings arrangement. Like most total cost of care payment models, CPC providers' ability to make decisions based on value is predicated on their access to data on the quality and cost patterns of the specialists to whom they refer patients. To facilitate value-based referrals, the state has invested in data infrastructure to share reports, known as referral reports, with providers

participating in the CPC program: these reports will include data on the specialists to whom providers refer their patients. As the state begins to tie opioid quality measures to financial incentives in EOCs, it also plans to use performance on its measures to inform PCMHs' referral reports, such as potentially excluding providers who do not meet opioid quality targets from lists of "high-quality providers."

CONCLUSION

While not at the forefront of state SIM innovation efforts, the smaller-scale initiatives described in this paper hold promise to improve quality and health outcomes for target populations. Demonstrating some success, Massachusetts, Tennessee, and Ohio have sought to integrate these initiatives into broader delivery system reform efforts, securing sustainable funding and support. MCPAP and MCPAP for Moms both have secured a source of ongoing funding following SIM, and program staff is seeking to determine how the program will be incorporated into the Commonwealth's new Medicaid ACO model. Tennessee's LTSS reforms, which have shown improvements in ERC spending and health outcomes, as well as greater consistency among providers as they adopt quality improvement efforts and prepare for value-based reimbursement, provide a framework that will continue to be refined post-SIM. Lastly, the integration of opioid quality measures into Ohio's EOC initiative has allowed the state to leverage its SIM investments in payment transformation to promote best practices in prescribing opioid medications, dovetailing with its other efforts to intervene in the public health crisis of opioid addiction and overdose deaths. The state plans to expand use of opioid quality measures to its primary care transformation efforts in the near future. These initiatives serve as valuable examples for other states looking to improve a particular aspect of their health systems' performance and may serve as a starting point for states interested in tackling delivery system and payment reforms in these issue areas.

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