
Sustaining State Innovation Model Investments: Key Factors in Round One States

May 2019

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ACKNOWLEDGEMENTS

The authors thank officials and stakeholders in SIM states for their cooperation and willingness to be interviewed for this paper. We would also like to extend our gratitude to the State Innovation Group at the Center for Medicare and Medicaid Innovation (CMMI) for their support of this work and the members of the SIM Initiative technical assistance team at NORC at the University of Chicago, Center for Health Care Strategies, and State Health Access Data Assistance Center (SHADAC) who offered input and helpful suggestions during the review process.

This paper was supported by the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS), under contract HHSM-500-2011-00002I/HHSM-500-T0016. The views expressed in this article are solely those of the authors and do not necessarily represent the policy or views of CMS.

Executive Summary

The State Innovation Model Initiative (SIM) provided funding to states to design and test payment and delivery system reforms to improve care and lower costs in Medicare, Medicaid, and the Children’s Health Insurance Program. The Center for Medicare and Medicaid Innovation (CMMI) awarded over \$300 million to Round One states to design, further develop or test state health care innovation models. Given the immense investments made by CMMI and the ambitious goal of transforming states’ health care delivery systems, the aspiration was that health care delivery and payment reforms launched under SIM would be institutionalized post-award.

Methods

Key factors that contributed to maintaining Round One SIM investments beyond the award period were examined using concepts from implementation science and a sustainability framework. The applied framework (Shediac-Rizkallah and Bone, 1998) identifies three major influences on the long-term sustainment of investments: (1) project design and implementation factors (encompassing both characteristics of the innovation and implementation process); (2) factors in the organization; and (3) factors in the external environment. Interviews with state SIM stakeholders, as well as a literature review of SIM-related state materials, including operational and sustainability plans and publicly available materials were analyzed to identify themes in how the framework factors influenced sustainment in each of the Round One states.

Findings

All six states had sustained SIM investments related to Medicaid payment and delivery system reform; however, in three states specific features of these models were discontinued. Three states had investments in cross-payment alignment. While two of these states sustained these payment models after SIM, two of the three states discontinued the task forces and stakeholder associated with these efforts. All states made one-time investments in supports across providers such as HIT, health information exchange, and data analytics. Common factors that contributed to the sustainment of SIM investments include: building on existing state and federal initiatives; engaging a wide variety of stakeholders; providing training and up-front capacity building; investing in evaluation activities; and identifying executive leadership champions.

Conclusions

Having an understanding of the conditions and influences that supported the viability of states’ SIM models will help to inform the long-term sustainability of other large-scale state-based delivery system and payment reform investments.

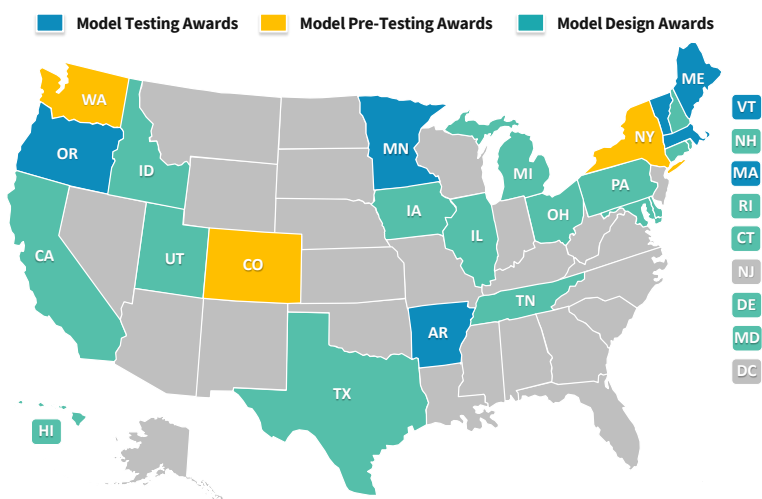
Introduction

The federal State Innovation Models (SIM) initiative provides funding to states, under cooperative agreements, to design and test innovative, state-based health care delivery and payment reforms. The goal is to improve care and lower costs in Medicare, Medicaid, and the Children’s Health Insurance Program. In addition to this primary goal, SIM is designed to strengthen state health information technology (HIT) capacities, as well as bolster the health care workforce.¹ A central premise of SIM is that states have important policy and regulatory authorities to effect change, as well as the ability to convene a broad array of public and private stakeholders. The latter, in turn, can help support multi-payer participation in health care innovations (i.e., Medicare, Medicaid, private payers).

In 2013, the Center for Medicare and Medicaid Innovation (CMMI) awarded nearly \$300 million in Round One SIM awards to 25 states to design, further develop, or test state health care innovation models. Six states — Arkansas, Maine, Massachusetts, Minnesota, Oregon, and Vermont — received \$250 million in Model Test awards to implement and test new models, with model test periods ranging from three and a half to five years.² Three states — Colorado, New York and Washington — received Pre-Test awards to further develop and refine their models for testing. An additional 16 states received \$31 million in Model Design awards to develop innovation plans over six months. In 2014, under SIM Round Two, 11 additional states received Model Test awards, and 21 states received Model Design Awards, totaling nearly \$680 million.³ The map in **Exhibit 1** shows the round and type of SIM award participating states received.

While SIM states have had broad flexibility to customize their delivery system and payment reform models, three common themes emerged across Round One states. These include: (1) fostering multi-payer and provider commitment to participate in value-based reimbursement; (2) promoting health care models that improve coordination across providers, including patient-centered care and behavioral health integration; and (3) promoting data exchange across purchasers, payers

Exhibit 1. States that Received Test, Pre-Test, and Design Awards



and providers to improve cost and quality outcomes.⁴ Round One states recognized that Medicaid was a crucial leverage point, and used their funding to invest in: episodes of care; patient-centered medical homes (PCMHs); accountable care organizations (ACOs); Medicaid health homes; improved data-sharing capacity; and enhanced data analytics and quality measurement alignment. **Exhibit 2** offers an overview of key Round One SIM components.

Exhibit 2. Key Components of Round One SIM Initiatives

	AR	ME	MA	MN	OR	VT
Patient-Centered Medical Home (PCMH)	✓	✓	✓	✓	✓	✓
Medicaid Health Homes (chronic conditions and behavioral health)		✓			✓	
Primary Care/Behavioral Health Care Integration		✓	✓		✓	✓
Episodes of Care	✓					
Accountable Care Organizations (ACOs)		✓	✓	✓*	✓**	✓
All-Payer Claims Database/Multi-Payer Patient Portal	✓	✓	✓	✓		
Accountable Communities of Health				✓		

Source: Authors analysis of SIM program documents.

*Integrated Health Partnerships Model

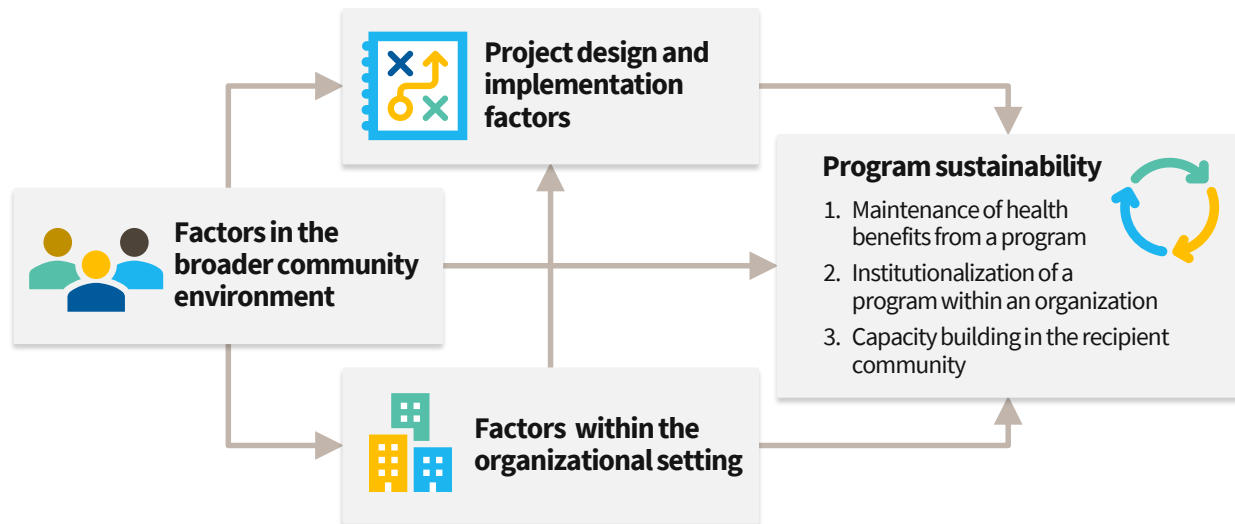
**Coordinated Care Model

Given the immense investments made by CMMI and the ambitious goal of transforming states’ health care delivery systems, it was CMMI’s aspiration that models launched under SIM would be institutionalized post-award. Guided by a framework on program sustainability, this paper synthesizes findings from interviews with state SIM personnel, such as SIM project directors and agency staff charged with leading SIM work, as well as a literature review of SIM-related state materials. Understanding the conditions and influences that supported or prevented the viability of states’ SIM components will help to inform the long-term sustainability of other large-scale investments in state initiatives.

Sustainability Framework

We conceptualize program sustainability using two complementary frameworks. The first, developed by Fisher, Shortell, and Savitz, suggests that the implementation, adoption, and eventual outcomes of innovation are informed by the external environment and the characteristics of the adopting organization, in addition to the specific innovation features.⁵ The second framework, developed by Shediac-Rizkallah and Bone identifies three major influences on long-term viability of investments: (1) project design and implementation factors (encompassing both characteristics of the innovation and the implementation process); (2) factors in the organization; and (3) factors in the external environment (see **Exhibit 3**).⁶ The first group of influences, *project design and implementation factor* includes: project effectiveness; project duration; project financing; project type; and training. In the context of SIM, *factors in the organization* refer to state characteristics, such as: institutional strength; integration with existing programs/services; program champions and leadership. Finally, *factors in the external environment* include the social, political, and economic factors that might have bearing on the project design, as well as the involvement of key community stakeholders.⁷ These factors are intended to serve as potential guidelines for sustainability planning.⁸

Exhibit 3. Factors Influencing Adoption and Sustainability of Innovation




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 **PROJECT DESIGN AND IMPLEMENTATION FACTORS**

<p>Project Negotiation Process - Are project approaches and goals discussed with the community? Are community needs driving the program?</p>	<p>Project Duration - What is the project's grant period? Is it a new project or is it an existing program that is receiving additional funds?</p>	<p>Project Type - What type of project is it (e.g., preventive vs. curative)?</p>
<p>Project Effectiveness - Is the project (perceived as) effective? Is it visible? What are the secondary effects of the program?</p>	<p>Project Financing - What are the sources of funds for the program? What are the community's local resources? Can the community afford the program once project funding is over?</p>	<p>Training - Does the project have a training component?</p>

 **FACTORS IN THE ORGANIZATION**

<p>Institutional Strength - What organization will be implementing the program? How mature (developed, stable, and resourceful) is this organization?</p>	<p>Integration with Existing Programs/Services - Are goals, objectives and approaches pre-specified or are they adapted to the local population and setting and over time?</p>	<p>Program Champion/Leadership - Is there a program champion? What are his/her attributes?</p>
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 **FACTORS IN THE EXTERNAL ENVIRONMENT**

<p>Socioeconomic and Political Considerations - How favorable is the general socioeconomic and political environment for the sustainability of the program?</p>	<p>Community Participation - What is the level of community participation? What is the depth/amount of involvement? What is the range of involvement/types of activities?</p>
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Source: Adapted from Shediak-Rizkallah and Bone, 1998

Methodology

Guided by the framework in Exhibit 3, we conducted thematic analysis of primary and secondary qualitative data to identify common topics and issues that illustrate the factors that have contributed to, or inhibited, the sustainment of SIM investments in Round One Test states. Secondary data sources included publicly available resources, including SIM operational plans, sustainability plans and annual reports. Primary data sources were notes and transcripts of interviews with state SIM staff involved in decision-making during the SIM Round One Model Testing period, such as the project director or agency staff charged with leading SIM work. Interviews sought to gather SIM leaders' insights on the factors driving sustainability of their SIM-related efforts. A common set of questions was used for each informant that aligned with the factors influencing adoption of innovation illustrated in Exhibit 3, including discussion of program design and implementation features and factors relates to the state's internal and external environments (see Appendix: Interview Protocol).

As each state's SIM initiative comprised several components (as shown in Exhibit 2), we considered a single component of a state's SIM effort (e.g., patient-centered medical homes, episodes of care, all-payer claims database) to be sustained if some element of the original component was *institutionalized*, or still in place, after the end of the award, even if it had changed from its original design.

Due to limitations in the available data, we were unable to assess the extent to which each factor in the sustainability framework was present or absent for each SIM component. As such, this analysis focused on identifying cross-cutting themes in the sustainability of SIM investments in Round One states and providing case examples that illustrate those themes. The findings presented here are limited to the six Round One SIM states, and while they may not be generalized to the 11 Round Two states, these findings may inform future mixed-method analyses that are suited to the identification necessary and sufficient conditions for the sustainability of state-led health reform efforts.

Findings: SIM Investments and Factors Affecting Sustainability

Most SIM-related investments made by Round One states can be categorized as either Medicaid payment and delivery system reforms, such as episodes of care, patient-centered medical homes (PCMHs), health homes and accountable care organizations (ACOs); multi-payer alignment across initiatives; changes to care delivery and the providers that deliver care; or supports to multiple providers, such as HIT, data analytics, and technical assistance. As shown in Exhibit 4, all six states had investments in Medicaid payment and delivery system reform and supports across multiple providers; four invested in changes to care delivery or the providers delivering care, and three invested in multi-payer alignment across initiatives.

Exhibit 4. States with One-time, Sustained and Discontinued Investments, by Category of SIM Investment

CATEGORIES OF SIM INVESTMENTS	STATES WITH INVESTMENTS*	ONE-TIME (# STATES)	SUSTAINED (# STATES)	DISCONTINUED (# STATES)
Medicaid payment and delivery system reforms**	6	0	6	3
Multi-payer alignment across initiatives	3	0	2	2
Changes to care delivery and health care providers	4	1	3	1
Supports across multiple providers***	6	6	3	1

Source: Authors analysis of program documents and interviews with SIM project leads.

* States may have more than one investment in a given category, so columns may not sum to number of states with investments in a category.

** (e.g., episodes of care, patient-centered medical homes, health homes, accountable care organizations)

*** (e.g., HIT, data analytics, and technical assistance)

All six states sustained most aspects of their Medicaid reforms; however, three states discontinued specific features or derivatives of these models, such as expanding to special populations or rolling out new episodes of care. All states made one-time investments in supports across providers, such as in HIT capabilities. Sustained investments in provider supports in three states primarily related to data analytics and technical assistance associated with payment models. Two states sustained investments in multi-payer models; however, two states discontinued the task forces and stakeholder meetings associated with multi-payer initiatives. Three states

sustained investments in changes to care delivery and the providers delivering care, such as provider-community partnerships and telehealth models.

The following sections explore factors related to project design and implementation, organizational dynamics, and the external environment that Round One SIM Test states attributed to sustaining components of their models. Exhibit 5 (page 18) provides examples of activities Round One SIM Test states engaged in to sustain their innovations.

Project Design and Implementation Factors



Among the factors that played a role in SIM model design and implementation, interviewees attributed the following factors to have been most helpful in sustaining various SIM investments: (1) community engagement in the design process (project negotiation); (2) the defined time period of the award (project duration); (3) the establishment of training and learning components to support practice transformation (training); and (4) evaluation results (project effectiveness). Factors within the framework that did not apply in the SIM context include project type, and are not discussed in this paper. (Note: Project type was deemed not applicable in this review, as the nature of state SIM models were neither curative nor preventive, per the framework outlined by Shediak-Rizkallah and Bone.)

PROJECT NEGOTIATION PROCESS

Extensive stakeholder engagement during the model design process both pre-award and during the SIM period ensured early input and buy-in on the design and support of SIM components. States convened payment reform committees, value-based insurance design workgroups, and other SIM taskforces, bringing together providers, payers, and patient advocates to work through details of SIM models, make recommendations on how to spend funds and gather feedback. States also expanded these conversations to include public health, long-term services and supports providers, and community service providers. In many cases, these cross-stakeholder groups met frequently—in some cases, monthly—which helped develop relationships that previously had not existed.

Cross-sectoral activities fostered long-term commitment and engagement in work on shared priorities that was critical to the institutionalization of SIM components and helped “catalyze communication” about continued health reform efforts in a post-SIM world. This was particularly evident for Medicaid reforms. For example, states remain committed to implementing or refining Medicaid reforms that aim to improve quality and reduce costs, and while the formal structure of SIM is no longer in place, states continue to engage providers, communities, and agencies outside of Medicaid to effect change. The Oregon Health Authority Transformation Center, for example, continues to convene the Oregon Council of Clinical Innovators, a statewide network of multidisciplinary health system leaders dedicated to building leadership capacity to implement health system transformation projects in local communities and create a network of experts to support Oregon’s coordinated care model.⁹ Similarly, in Arkansas the state continues to develop its episodes of care model, convening regularly with payers and providers to evaluate and refine episodes.

Provider participation and support was a critical influence on providers remaining committed to delivery system transformation activities beyond SIM funding, and “meeting providers where they were” facilitated providers’ participation in transformation activities. States sought provider input on various aspects of states’ SIM components, including alignment of quality measures and strategies to transition providers to value-based reimbursement and behavioral integration, and used this information to shape program design in ways that would ultimately support adoption and sustainability of some components.

Through engagement activities, such as subcommittee and workgroup meetings, states adapted model components to encourage and facilitate their adoption. States also used information gleaned through rapid-cycle evaluations (see project effectiveness) to modify technical assistance to better support providers in the adoption of new care delivery and payment models. Recognizing the limited efficacy of their Care Management Learning Collaborative, Vermont transitioned to provide more one-on-one support. In addition, Minnesota and Arkansas intentionally created different “entrance points” for primary and specialty care providers to transition to patient centered medical homes, and tailored technical and financial support to ensure that most, if not all, providers were able to “move along the transformation continuum” and acquire the capacity and knowledge necessary to operationalize SIM care delivery models on the ground. This staggered design meant providers could adapt at their own speed and evolve at a reasonable pace, making it easier for more providers to participate in SIM activities.

To some degree, states used provider and organizational interest in pilot programs, as well as provider feedback during training events, to inform funding decisions. For example, Minnesota originally earmarked SIM dollars to be spent on state data analytic infrastructure, but after gathering input from providers participating in the state's Integrated Health Partnerships model, the state identified a need for funding at the provider level (rather than at the state level). It re-directed about half of its originally earmarked funds for state-level data infrastructure enhancements toward provider-level data analytics capacity improvements.

While informants noted that the willingness to collaborate around reform efforts has endured, in many cases the infrastructure and resources to formally bring these groups together no longer exists. Vermont noted that convening key stakeholders required both resources and staff capacity, which were not as available post-award. Similarly, two key Minnesota taskforces launched under SIM (i.e. the Multi-payer Alignment and community Advisory Taskforces) were formally discontinued at the close of the award. As a result, states have found momentum on efforts has waned or is at risk of waning.

TRAINING

Provider training and capacity-building activities and HIT investments funded under SIM accelerated providers' adoption of new care delivery models and sustained their participation in these models beyond SIM. Training and capacity-building efforts included practice transformation support centers, learning collaboratives and technical assistance. Many of these trainings were one-time investments and did not require ongoing support to be effective or have lasting effects. Some states deliberately used a train-the-trainer model so that newly established training modules were maintained within communities, provider settings or by state transformation entities.

Many HIT efforts were also one-time investments that helped develop HIT infrastructure, including web-based provider portals, admission discharge and transfer (ADT) feeds, and other data analytics and reporting programs. SIM funds were ideal for this upfront infrastructure investment, and have resulted in lasting community resources to maintain HIT tools that enable providers to act on cost and quality data. While some elements of these provider supports have been discontinued, most states still provide some technical assistance support, which has helped sustain and even grow delivery transformation models launched under SIM.

PROJECT EFFECTIVENESS

States used internal program evaluation results and ongoing monitoring of implementation milestone achievement to assess the continuation of their SIM investments. All states noted that they continually assessed investments for project effectiveness and impact and remained intentionally flexible in order to redistribute funds as needed. As part of the terms and conditions of the SIM award with CMMI, states were required to use SIM funds to conduct their own evaluations, which helped inform decisions to sustain certain successful activities. States tracked annual and quarterly milestones and, used this information to: (1) guide internal decision making on sustained program activities; (2) advocate for and secure state appropriated funds to support effective innovations; and (3) guide the development of state legislation to introduce or augment reforms (i.e., health information exchange).

States used their evaluation and monitoring results to make adjustments to innovation models to better meet program goals. Informants noted the importance of being able to pivot quickly to ensure that they were able to pursue funding for more promising activities that had a higher likelihood of impact and sustainability. SIM’s annual funding approval process provided some flexibility in how states could propose to use funds, allowing them to redistribute funds to the highest-value activities. For example, Massachusetts used evaluation results of their e-Referral program evaluation — a bidirectional referral platform between clinic sites and community-based organizations — to inform requirements for use among ACOs. Massachusetts found they would have greater traction by pivoting from a primary care transformation focus to an ACO model that had greater stakeholder buy-in and interest.

PROJECT DURATION AND FINANCING

The time-limited nature of the SIM initiative forced states to make strategic funding decisions. Most states offered one-time grants to health care organizations and providers, which enabled them to build capacity to participate effectively in delivery system and payment reform models, and would not require ongoing funding beyond the SIM project. These one-time investments were earmarked for HIT improvements, gap analyses, and training activities such as learning collaboratives that supported practice transformation. In some instances, however, short term nature of the award meant the time required to fully implement and institutionalize new delivery system and payment reform models was insufficient.

Organizational Factors

States indicated that commitment across state agencies in implementing SIM, alignment with existing programs and initiatives, and program champions all contributed to the sustainment of various SIM components.



INTEGRATION WITH EXISTING PROGRAMS / SERVICES

Strategic integration with existing state programs and federal initiatives was cited as one of the most critical factors for sustaining SIM activities and goals. For example, Arkansas sought to expand reimbursement and care delivery reforms that are central to the Comprehensive Primary Care (CPC) Initiative, a multi-payer initiative of CMMI designed to strengthen primary care¹⁰, to further the patient-centered medical home model within the Medicaid population. Through its SIM efforts, Arkansas extended its PCMH model requirements of their CPC initiative to its Medicaid population. Leveraging existing programs helped states to extend the reach of SIM efforts, and with demonstrable success and buy-in from providers, these programs remain in place, sustaining the objectives set forth in the SIM vision.

Building on the experience of health homes for individuals with behavioral health conditions launched under SIM, in 2017, Maine launched a Medicaid health home program focused on opioid use disorder, which delivers medication-assisted treatment, opioid dependency counseling, and comprehensive care management for eligible MaineCare members with opioid use disorder. Several states have pursued additional federal initiatives and policy levers to continue to build on work launched under SIM, including Medicaid Section 1115 waivers and State Plan Amendments. Massachusetts is using funds available through the Delivery System Reform Incentive Program (DSRIP) to encourage providers and payers to continue to participate in the transition to the state’s ACO model. The ACO was developed with SIM funding to move the health care landscape to be outcomes- and value-driven.

Through SIM, many Round One states expanded on promising state programs already planned or operating within the state, enabling states to mature and accelerate innovations by leveraging the expertise and investments already in place. Minnesota, for example, expanded on an accountable care type model that predated SIM, and was able to engage additional providers under SIM, and continue to spread operations post-SIM funding. Some states intentionally targeted “well-positioned” providers to apply for SIM-funded grants to increase the likelihood that transformation efforts would be successful. States focused on primary care transformation, for example, made an intentional decision to focus significant resources on more advanced providers so they

could “progress exponentially” in their payment and care delivery model evolution. The strategy was to build on an already-strong foundation in order to reach a high level of practice transformation among this cohort. Minnesota allowed for multiple rounds of funding opportunities for capacity building and clinical workflow redesign such that providers could apply for additional grants after achieving gains in the first round. The goal was to advance a cohort of providers so that when funding ceased, they would be high-functioning, patient-centered medical homes.

INSTITUTIONAL STRENGTH

Dedicated entities to oversee reform efforts under SIM saw continued engagement from state and agency staff on transformation efforts. Most Round One states elected not to create new offices or created only temporary staff positions to support SIM program activities. They instead housed SIM operations within existing departments and agencies. Oregon, on the other hand, established the Transformation Center, a centralized transformation office that served as a “hub” for SIM activities and health system change more broadly. It convened stakeholders, coordinated and evaluated SIM activities, and disseminated successful programs. While no longer managing the day-to-day activities of SIM, the Oregon Transformation Center continues to engage in health reform activities, including those developed under SIM, as well as practice transformation assistance, evaluation of health care innovations, and health care quality improvement activities. The Transformation Center continues to receive state budget support post-SIM, which demonstrates its importance as a contributor to the sustainability of SIM’s health transformation activity.

PROGRAM CHAMPION / LEADERSHIP

Commitment from executive leadership and agency leads provided credibility to SIM delivery system reform efforts, leading to greater engagement and action from multiple state agencies. While SIM applications required sign-off and submission from Governors, genuine executive leadership commitment to the process played a tremendous role in both the implementation and ongoing sustainment of various SIM activities. In addition to the gubernatorial support, involvement of agency leads, such as the Arkansas Department of Human Services Director and the Maine Health and Human Services Commissioner, provided a legitimacy to SIM activities. SIM leadership teams in Vermont, for example, had “enough executive horsepower” to influence state budget decision-making, which helped secure funds to support efforts started under SIM after the termination of the award. This executive leadership sponsorship also fostered cross-agency collaboration, which previously had not occurred to such an extent. SIM funds helped to create an infrastructure that enabled external stakeholders,

agency leads and staff within state government to meet regularly and closely align with the SIM vision. In many instances, states credited SIM with continued cross-agency collaboration on health reform activities after SIM funding ceased.

In addition to executive leadership commitment, many states also cited the support of internal champions or visionaries as a critical factor in shepherding state health innovation plans from concept to implementation. Key informants reported that support from governors, Medicaid directors, health commissioners, and other executive leaders was critical to initiating SIM, and their commitment to sustain health reform activities endures beyond the end of the award. These champions had worn various hats within state government, both through the SIM award period and their respective professional careers, and had a deep appreciation of various SIM model features, including behavioral health integration, alternative payment models, and ACOs. In many cases, these internal champions remain committed to work in these areas, and “their passion remains” even though SIM is over.

External Factors

SOCIOECONOMIC AND POLITICAL CONSIDERATIONS



History of health care reform efforts created an environment that was conducive to sustaining SIM activities.

Prior to receiving the SIM award, most Round One states had already made inroads toward conceptualizing and implementing delivery system and payment reforms. Some states had developed health care transformation roadmaps, which helped to crystalize key decisions about SIM investments. Similarly, states with a long history of implementing health care reforms indicated that providers and payers were prepared to take on more sophisticated alternative payment models, including downside risk, and also had broad-based support and buy-in from key stakeholders to test innovative delivery system reforms. Some states cited political pressure from within Governors’ offices to address spending rates and growth within Medicaid, which reinforced the need for delivery system transformation projects to improve quality *and* reduce costs.

Changes in administration and shifts in state priorities in some cases did not align with the original SIM vision and challenged sustainability.

Without executive leadership support to promote SIM activities, progress on model adoption was diminished, and when funding ceased, these activities often ended. In Maine, changes at the gubernatorial level and within the department of health and human services resulted in new health reform priorities, which did not fully align with planned activities. Other states, however, reported that changes in administration, while slowing the

implementation process somewhat, did not hinder progress under SIM. Committed program staff, who were deeply knowledgeable about SIM objectives, helped to maintain momentum (see program champions). In other cases, a shift in administration reoriented SIM activities to create a more cohesively aligned portfolio of work. This refocusing created a more viable model, and one that continues to be implemented post-SIM.

Notably, the opioid epidemic was a critical external shock to the public health system that captured the focus of many state governments. Where present, it tended to eclipse SIM as a state priority, diverting attention and resources away from payment and delivery system reform innovations started under SIM.

COMMUNITY PARTICIPATION

Thoughtfully and systematically soliciting input from the community ensures support and buy-in for health care transformation efforts. In many instances, states had previously established workgroups focused on health reform activities and leveraged this expertise within the community to garner support and program design input. In addition to the stakeholder engagement that included payers and providers in the pre-award and design phase (see project negotiation process), feedback from community-based stakeholders throughout the award period contributed to continued support of SIM components. Massachusetts noted it ran every major decision by the state’s active advocacy community to avoid unintended consequences and ensure the most vulnerable populations were being considered. Oregon launched a “statewide roadshow” of public meetings before submitting its SIM proposal to CMMI, and continues to see its ongoing and extensive community engagement as a cornerstone of its approach to policy work.

Community stakeholders helped to define the priorities in Minnesota’s health reform roadmap, which was used to orient the state’s SIM activities and continues to guide health reform activities. Key informants felt that this early collaboration with community partners helped create buy-in and ownership of reform activities, an investment at the community level that has been sustained post-award.

These “state cultures” of innovation, and community engagement have made health care reforms both a value and priority within states and the culture continues to sustain SIM components post-award.

Exhibit 5. Examples of Round One SIM Sustainability Activities



PROJECT DESIGN AND IMPLEMENTATION FACTORS

Project Negotiation Process

- States relied on extensive stakeholder engagement, both pre-award and during the SIM period, to ensure input and buy-in on the design and implementation of SIM model components (MA, MN, OR).
- Provider support and engagement was a critical influence on providers remaining committed to delivery system transformation activities (MN, OR, VT).
- States intentionally created different ‘entering points’ for providers to adopt new care models, and tailored support to ensure that all providers were able to move along the transformation continuum (MN)

Project Duration

- The time-limited nature of the SIM initiative forced states to make strategic decisions about whether funded activities required a one-time investment or ongoing funding (AR, MA, ME, MN, OR, VT).

Project Effectiveness

- Requirement to conduct their state-led evaluations, which helped inform decisions about which features/activities to sustain (AR, MA, ME, MN, OR, VT)
- States continually assessed investments, and were intentionally flexible to redistribute funds if needed. In addition to conducting a formal evaluation, state SIM staff were continually in contact with providers and key players to understand the implications and effectiveness of their investments (AR, MA, ME, MN, OR, VT).

Project Financing

- SIM funds were ideal for one-time investments that helped develop HIT infrastructure, and have resulted in lasting community resources that continue to enable providers to be able to act on cost and quality data (AR, MA, ME, MN, OR, VT).

Training

- States used a train-the-trainer model, so that assistance and training modules that were created were maintained within communities, provider settings, or by state transformation entities (MA, MN, VT).



FACTORS IN THE STATE

Institutional Strength

- Most Round One states did not create new offices or created only temporary staff positions to support SIM program activities and housed SIM operations within existing departments and offices (AR, MA, ME, VT)
- Establishment of centralized transformation “hub” for both SIM and health system change more broadly, which continues to receive state support post-SIM (OR).

Integration with Existing Programs/Services

- Many Round One states proposed models that expanded on promising programs already operating within the state (MN, OR).
- Conscious alignment with existing programs and federal initiatives helped to further develop SIM models and helped to grow and sustain them (AR, MA, ME, MN, OR, VT).

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Program Champion/Leadership

- Support from Governors, Medicaid directors, health commissioners and other executive leaders was critical to initiating SIM, and their commitment to sustain health reform activities endures beyond the end of the reward (MN, OR, VT).
- Champions at executive and agency level have a deep appreciation and understanding of various SIM model features (AR, MN, OR).



FACTORS IN THE EXTERNAL ENVIRONMENT

Socioeconomic and Political Considerations

- States with a long history of implementing health care reforms indicated that providers and payers were prepared to take on more sophisticated alternative payment models and had buy-in from key stakeholders (MA, OR).
- A shift in administration reoriented SIM activities to create a more cohesive, aligned portfolio of work and a more viable model (MA).
- Some states cited political pressure from within Governors' offices to address spending rates and growth within Medicaid, which focused the design and implementation of delivery system transformation projects to improve quality and reduce costs (MA, OR, VT).

Community Participation

- SIM funds enabled a broader set of stakeholders to come together consistently, bridging work across agencies as well as within the community, and that these relationships and collaborations continue post-SIM (AR, MA, ME, MN, OR, VT).
- Extensive engagement of the broader public, including statewide public meetings and consultation with advocates for vulnerable populations, built on a history of healthcare reform work (MA, MN, OR, VT).

Conclusion

Based on the sustainability framework developed by Shediac-Rizkallah and Bone, a number of common factors have helped to sustain SIM investments: (1) building on existing state and federal initiatives; (2) engaging a variety of stakeholders, especially providers and community members; (3) providing training and knowledge transfer to other providers/organizations; (4) investing in evaluation activities; and (5) identifying executive leadership and project champions. Within the external policy environment, states have used a number of policy levers to continue SIM investments, such as Medicaid Section 1115 waivers; Medicaid State Plan Amendments; state appropriations; and state legislation.¹¹

SIM offered significant funding to states to test new delivery system and payment reform models. While the SIM initiative was designed to test the viability of these models, the hope was that successful approaches could be sustained beyond the grant funding period. Understanding the factors that contribute to the sustainment of SIM investments will help inform other large-scale federal health care investments by offering key considerations to program and policy leaders as they push to institute and promote new health care delivery approaches.

Appendix: State Innovation Model Sustainability Planning Factors and Rationale: Interview Protocol

1. What key components of your SIM model have been sustained post-award?
2. What key components of your SIM models were discontinued at the close of the SIM grant?
 - a. Were there some components you have liked to sustain but were unable to do so?
3. For SIM initiatives/programs that were discontinued either during the grant or at the end, why were those discontinued?
 - a. What criteria did you use to make those decisions?
4. We're interested in understanding what rationale [state] used to determine which initiatives/programs would receive a one-time investment versus ongoing financial support over the course of the grant.
 - a. Can you describe the key considerations and decision-making process?
 - b. Who was involved in the decision-making?
 - c. What were the major concerns or sticking points?
5. What systems were in place to enable you to evaluate progress on certain SIM components and whether to continue these investments beyond SIM?
6. In what ways was performance used to modify or make any mid-course corrections on any SIM components?
7. Were there any unintended consequences of your SIM models/implementation strategy? If so, did these have an impact on [state's] ability sustain certain components?
8. What environmental characteristics/elements do you think resulted in certain SIM investments being sustained post-grant period? (i.e., political, economic, market forces, etc.)
9. What characteristics within [state] do you think contributed to sustained SIM investments? (i.e., champions, infrastructure, alignment with existing programs)
10. What design features of your SIM model(s) do you think contributed to the implementation and sustainment of key SIM design components (i.e., provider buy-in, champions, infrastructure)?
11. What factors, or combinations of factors, do you think are the most important considerations for sustainability of SIM work? Why? To what extent were these factors a challenge?
12. What advice would you share with Round Two states currently developing their sustainability plans?

ENDNOTES

- ¹ Sager J. SIM Round 1 Grant State-Level Summary and Analysis. Community Catalyst website. <https://www.communitycatalyst.org/resources/publications/document/SIM-Round-1-Summary-pdf>. Published November 2015. Accessed March 7, 2019.
- ² RTI International. *State Innovation Models (SIM) Initiative Evaluation Model Test Year Five Annual Report*. Research Triangle Park, North Carolina. RTI International; 2018. <https://downloads.cms.gov/files/cmmti/sim-rd1-mt-fifthannrpt.pdf>. Accessed March 7, 2019.
- ³ State Innovations Models Initiative: General Information. Centers for Medicare & Medicaid Services website. <https://innovation.cms.gov/initiatives/state-innovations/>. Accessed March 7, 2019.
- ⁴ RTI International. *State Innovation Models (SIM) Initiative Evaluation Model Test Base Year Annual Report*. Research Triangle Park, North Carolina. RTI International; 2014. https://downloads.cms.gov/files/cmmti/SIM-Round1-ModelTest-FirstAnnualRpt_5_6_15.pdf. Accessed March 7, 2019.
- ⁵ Fisher E, Shortell S, Savitz L. Implementation Science: A Potential Catalyst for Delivery System Reform. *Journal of the American Medical Association*. 2016; 315(4): 339-340.
- ⁶ Shediac-Rizkallah M, Bone L.R. Planning for the Sustainability of Community-Based Health Programs: Conceptual Frameworks and Future Directions for Research, Practice and Policy. *Health Education Research*. 1998; 13(1):87-108.
- ⁷ Ibid
- ⁸ Ibid.
- ⁹ Transformation Center. Oregon Health Care Authority website. <https://www.oregon.gov/oha/HPA/CSI-TC/Pages/Council-Clinical-Innovators.aspx>. Accessed March 7, 2019.
- ¹⁰ Comprehensive Primary Care Initiative. Centers for Medicare and Medicaid Initiatives. Available at: <https://innovation.cms.gov/initiatives/comprehensive-primary-care-initiative/>. Accessed March 7, 2019.
- ¹¹ RTI International. *State Innovation Models (SIM) Initiative Evaluation Model Test Year Four Annual Report*. Research Triangle Park, North Carolina. RTI International; 2018. <https://downloads.cms.gov/files/cmmti/sim-rd1-mt-fourthannrpt.pdf>. Accessed March 7, 2019.