Pennsylvania Plan

Pennsylvania is marshaling both public and private resources to evolve its delivery system from fee-for-service into one that is focused on value-based, outcome-driven health care. By leveraging patient-centered medical homes and accountable provider organizations (APOs), Pennsylvania can be successful in meeting its goal of high quality, sustainable, accessible and affordable health care. To support delivery system transformation, Pennsylvania will create community-based care management teams to provide highly-coordinated behavioral and physical health services to high-risk Medicaid members, strengthen its Health Information Exchange, implement a unified set of performance measures, enhance its data collection and reporting capabilities, expand its telemedicine infrastructure, and create a sophisticated Transformation Center to provide evidence-based technical assistance to provider practices and APOs. To integrate population health initiatives with provider transformation activities, the Department of Health is undertaking a multi-stakeholder state health improvement planning and implementation process. The goal is to improve population health by coordinating the health care delivery system and public health initiatives to reduce the prevalence of obesity and diabetes, as well as reduce tobacco use, improve childhood dental care, improve mental health service delivery, and improve service access for people with Alzheimer’s and Related Disorders. Performance targets for 2018 have been established for delivery system transformation, population health improvement and per capita cost savings. Pennsylvania has created a detailed operational plan with quarterly major milestones and performance targets. Finally, committed state leadership is in place to implement the Innovation Plan and the strong support of external partners.

By the end of 2018, Pennsylvania estimates that 1,348,859 Medicaid/CHIP beneficiaries, 531,616 Medicare beneficiaries 273,181 newly eligible and 5,222,068 commercial covered lives will be affected by transformation activities, representing 53% of Pennsylvania residents. Pennsylvania anticipates that 2,000 primary care practices will be involved in transformation activities and nine Medicaid MCOs and all major commercial payers will be supporting PCMH, APO or EOC payment models.

Pennsylvania is submitting the following request for $100 million in SIM grant funds:
- HIT (including HIE and telemedicine): $13,573,261.78
- Delivery system transformation support: $39,957,182.82
- Data collection and reporting: $17,104,875.00
- Population health improvement: $18,118,322.20
- SIM project management: $9,978,436.89
- Monitoring and evaluation: $1,266,875.39

**Plan for Improving Population Health**

The Commonwealth’s recently completed State Health Assessment (SHA)\(^1\) documents the current health of the population and identifies disparities based on geography, age, sex, race, ethnicity and income. Through the SHA, the Pennsylvania Department of Health (DOH) identified five major risk factors that most impact health: tobacco use/exposure, obesity/overweight and lack of physical activity, alcohol/drug use, mental health disorders, and oral health. DOH has begun a comprehensive community-based planning process consistent with the requirements of Appendix 1 of the FOA, which will result in a State Health Improvement Plan (SHIP). The stakeholder-oriented process uses evidence-based practices occurring locally to address health disparities as well as state and local health priorities. In line with the SHIP, the SIM Model Test application focuses on improving population health and outcomes with regard to obesity, tobacco use, diabetes, mental health, Alzheimer’s disease and related disorders (ADRD), and oral health.

**Planning process.** To receive accreditation by the Public Health Accreditation Board, DOH is engaged in a CDC-funded National Public Health Improvement Initiative, which includes developing the SHIP. Following a CDC-approved process, DOH is engaging stakeholders to identify priorities and evidence-based interventions, and implement those interventions to improve health behaviors and effectively utilize available health services. Scheduled to be completed by September 2015, the SHIP is being developed with a broad-based advisory committee composed of state health officials, health care institutions and provider associations, community-based organizations, local and state-elected officials, local public health officials, payers, purchasers, and other state agencies including transportation, insurance, public welfare,

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\(^1\)[www.portal.state.pa.us/portal/server.pt/community/healthy_schools,_businesses_and_communities/11601/state_health_assessment_page/1533419](www.portal.state.pa.us/portal/server.pt/community/healthy_schools,_businesses_and_communities/11601/state_health_assessment_page/1533419)
parks and conservation, and education. Throughout July 2014, DOH is holding six regional meetings to obtain local input regarding health care concerns and priorities. DOH then will work with the advisory committee to identify statewide priorities. Subsequently, six regional task forces will use the input to develop local strategies and initiatives, and identify initiative owners. Community-based Steering Committees will be responsible for implementing the local plans. DOH will provide analytic support and consultative services to the communities, including providing access to statewide data to provide community-specific reports and benchmarks to help in targeting initiatives and tracking impact, and providing guidance to support successful implementation. DOH local staff will participate in the Steering Committees. The Steering Committees will provide regular written updates and data reports to DOH, allowing for oversight and DOH sharing information to encourage rapid spread of innovation across the state.

Simultaneously, the Department of Public Welfare’s (DPW) Office of Mental Health and Substance Abuse Services (OMHSAS) is engaged in a stakeholder-centered planning process to address behavioral health service needs including those identified in the SHA. OMHSAS is working with DOH to align strategies as part of the SIM Model and SHIP implementation process.

Impact on improving population health. Leveraging the SHA findings and through SHIP, communities will be using a data-driven and community-preference approach to identify priority initiatives and to strategically deploy evidence-based resources that directly impact population health. The State has a number of programs in place focused on CMMI-identified priorities. The Pennsylvania Tobacco Control Program follows the CDC’s “Best Practices for Comprehensive Tobacco Control Programs” to implement a comprehensive, sustainable and accountable program, which includes nine different initiatives. The Pennsylvania Obesity/Overweight Initiative includes six community-focused and school-focused obesity prevention programs, three interventions to encourage increased physical activity, and two interventions to improve nutrition, particularly in low-income neighborhoods. DOH is also implementing a state-wide health literacy initiative with a consumer and provider component.

To enhance these current initiatives and improve population health, the State will use SIM funds to initiate or expand several key programs. DOH will expand a program focused on improving school-based food service and student physical activity level at 100 targeted school districts.
DOH will also **actively promote diabetes self-management programs** among Medicaid beneficiaries, providers and employers and work to **expand the number of accredited Diabetes Self-Management Education sites**. DOH will create a statewide referral system, for these self-management programs. OMHSAS is working with DOH to expand mental health and substance use screening strategies within PCMHs and establish PCMH options for individuals with serious mental illness (SMI) to improve the coordination of physical health and behavior health care for individuals with SMI and other behavioral health disorders.

To improve service accessibility for ADRD, **the Department of Aging (DOA) will use SIM funds to develop an ADRD information and referral website**, which will have resources for providers, patients and caregivers, and DOA will hold an annual ADRD summit designed to advance an integrated approach to caring for people with ADRD and their caregivers. DOH’s existing geo-mapping initiative described below will provide the locations of ADRD resources within each community to improve community awareness and engagement.

SIM funds will also be used to support a multi-faceted initiative led by the Pennsylvania Chapter of the American Academy of Pediatrics in collaboration with DPW and DOH to **expand its successful Healthy Teeth Healthy Children program** (HTHC) with a goal of 65% of children reaching age five without a cavity by 2018. Using the Educating Providers in the Community model, HTHC will reach out to 1,000 providers to implement clinical quality improvements including basic oral health preventive services. This program will target the primary care providers, the prenatal, obstetric providers and dental providers.

**Transform the health care delivery system.** Implementing the SHIP within local communities will be a shared responsibility of the community-based Steering Committees described above. Participants will likely include employers, consumers, providers, hospitals, places of worship, social service agencies, and representatives from DPW, DOH, DOA and the Department of Drug and Alcohol Programs. By creating common measures, all stakeholders will have shared accountability for achieving population health targets that are being measured by public health systems, health delivery providers, and insurers. Recommended population health measures are included in Part 8, Monitoring and Evaluation Plan. A core provider performance measure set will be developed during the pre-implementation year and will include corollary measures to the population health measures. **To promote accountability, the Pennsylvania Health Care Cost...**
Containment Counsel (PHC4) will provide regional reports using both population health and provider-supplied clinical data enabling the Steering Committees to track change, and identify and address issues. In addition to receiving DOH support, the regional hubs within the Transformation Support Center, discussed in Part 2, will be available to facilitate community-provider collaborative efforts on targeted initiatives.

To enable localities to easily identify available resources, DOH is currently developing extensive geo-mapping databases that will enable consumers and providers to enter geographic information and receive community-based resource information. The geo-mapping program is initially focusing on chronic conditions, Accountable Provider Organizations (APO) and PCMH locations, pharmacy networks and super-utilizer communities with an overlay of Care Management Teams (CMT).

*Decrease per capita health care spending.* The SHA identified five major risk factors impacting the health of Pennsylvania residents, including the three CMMI priorities of tobacco use, obesity/overweight and diabetes. These factors, plus ADRD, mental health, and diseases linked to poor oral health result in high medical spending. The initiatives being put in place, coupled with the SHIP development and implementation activities will increase consumer awareness of health issues, encourage lifestyle changes, promote healthier communities and reinforce delivery system transformation aims by focusing on prevention and reducing patient risk factors. Over time improved health behaviors will result in cost savings.

**Health Care Delivery System Transformation Plan.**

Pennsylvania has eight years of experience with primary care transformation through our Chronic Care Initiative (CCI). We have observed regions with slow initial transformation, and others with rapid transformation yielding impressive results quickly. We have observed significant performance variation within regions. We have learned many lessons, including that payment reform is necessary for delivery system transformation, but insufficient, by itself, to drive sustainable changes. For this reason, Pennsylvania’s Model Test initiative focuses on delivery system transformation support.

In a state as large as Pennsylvania—with more than 41,400 active physicians and nearly 200 acute hospitals—transformation is a major task. Today, 15% of Pennsylvania’s primary care
practices (PCP) are nationally recognized as patient-centered medical homes (PCMHs). To meet our target of 65% of PCPs having attained specified PCMH skills by the end of 2018, 2000 additional practices need to transform the way they deliver care. APOs are just starting to be formed by hospitals, health systems, physicians and other healthcare providers and require technical assistance to be successful under risk models, particularly in the areas of use of informatics to manage risk, and care management and care coordination across the continuum of care. Long-term care (LTC) facilities and community-based waiver service providers are starting to transform service delivery and integrate care with PCMH and APOs; however, they need assistance in redesigning workflow, utilizing telemedicine, and leveraging health information technology. Behavioral health providers are piloting PCMH models that utilize nurse navigators, PCP co-location and physical health consultation. The State will continue to encourage these options to facilitate better integrated care coordination activities and the sharing of appropriate clinical data. To provide the knowledge, expertise and peer learning opportunities needed to achieve transformation, a principal component of Pennsylvania’s SIM Model Test initiative is a Health Care Transformation Support Center (Transformation Center). The Transformation Center will be a multi-faceted resource to build organizational and professional capacity in support of a wide array of providers and thereby accelerate delivery system transformation. Core functions will include: a) training providers on PCMH and APO functions; b) supporting identification and dissemination of best practices that improve the management, integration and coordination of care across the continuum of health delivery services (long term care providers, behavioral health providers, PCPs, medical specialties, hospitals, medical equipment providers and public health organizations); c) providing trainings and tools that address patient engagement and self-care related to prevention and disease management; d) training providers on the effective use of data for population management; e) providing practice coaching resources, and f) developing and maintaining standard reporting metrics that measure Transformation Center effectiveness. The Transformation Center will also develop training modules for each targeted population health area (obesity, tobacco use, diabetes, mental health, LTC, ADRD and oral health) that focus on early diagnosis of patients at risk, best prevention and treatment practices and linkages to community resources.

The Transformation Center will be overseen by the DOH Center for Practice Transformation and Innovation (CPTI) and will consist of a central office and six regional hubs. The Transformation
Center Advisory Committee will provide input into the Transformation Center’s priorities and program initiatives. The central office will be managed by the Pittsburgh Regional Health Initiative (PRHI), which is renowned for its extensive work with providers to implement transformation models and achieve impressive results. The regional hubs will be selected through an application process managed by the central office, and will likely be comprised of existing organizations with demonstrated transformation support expertise. CPTI, with direction from the Advisory Committee, will oversee the central office’s performance of the following functions: a) guiding the direction of the transformation process and overseeing the activities of the hubs; b) developing training materials and practice tools that promote capacity development; c) developing an interactive website to share materials and build a learning community; d) planning and holding regularly scheduled peer learning conferences for provider and APO staff, including care managers, medical assistants, data analysts, and clinicians; e) disseminating a monthly e-newsletter spotlighting transformation successes, summarizing relevant literature, and promoting upcoming training opportunities; f) training practice facilitators on effective coaching skills and elements of the transformation models, and g) evaluating hub and provider performance data to identify issues and make strategic and program adjustments.

The regional hubs will be responsible for: a) planning and holding regional learning conferences targeting core PCMH and APO competences; b) providing practice facilitation support to practices; c) supporting EHR functionality and connectivity for behavioral health and long-term care providers; d) collaborating to identify and share lessons learned and best practices for statewide dissemination; e) hosting regional meetings of traditional and non-traditional medical neighborhood partners, including local transportation authorities, law enforcement, schools, and local public health agencies in support of SHIP implementation.

CPTI, with input from the Advisory Committee, will work with PRHI to comprehensively define the evidence base that will serve as the foundation for Transformation Center activity. We will draw upon the work of Pennsylvania innovators including Geisinger Health System (clinical pathways\(^2\)), Health Quality Partners (high-risk care management\(^3\)), and AF4Q South Central

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\(^2\) For an example, see [www.geisinger.org/professionals/services/osteo/index.html](http://www.geisinger.org/professionals/services/osteo/index.html)

\(^3\) See Colburn, Marcantonio, et al. “Effect of a Community-Based Nursing Intervention on Mortality in Chronically Ill Older Adults: A Randomized Control Trial,” July 17, 2012; [www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1001265](http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1001265)
Pennsylvania (patient engagement\textsuperscript{4}), and the Center for Health Care Strategies, Inc. (Serious Mental Illness Innovations Project)\textsuperscript{5}. In addition, the Transformation Center will engage Pennsylvania-based experts Ken Coburn, MD (high risk care management), Mary Naylor, PhD, RN (transitions of care), Linda Siminerio, PhD, RN (diabetes management) and Don Schwarz, MD (population health), among others, as consultants.

The Transformation Center will create a dynamic learning environment in which providers can learn from and be inspired by one another. To ensure the Transformation Center resources are utilized, the Test Model will apply a multi-part provider engagement strategy. First, we will partner with provider associations\textsuperscript{6} to communicate the pressing need for transformation, publicize the Transformation Center and also provide direct technical assistance. Second, we will partner with participating payers, who strongly support the Transformation Center concept, and have agreed to actively encourage provider participation. Third, working with our state-related academic medical centers, we will offer continuing education credits.

Pennsylvania will supplement the Transformation Center with other delivery system transformation supports. As described below, PHC4 and DPW will increase their gathering and reporting of performance measures. Pennsylvania will also remove barriers to delivery system transformation by improving HIE connections, reviewing state statutes and regulations, and facilitating a multi-stakeholder process to align payers’ performance accountability measure sets so that providers can focus their efforts on a common set of improvement goals.

To meet the workforce needs of PCMHs and APOs, Pennsylvania will implement an enhanced Loan Repayment Program for geriatricians and behavioral health providers – physicians, nurse practitioners and physician assistants – serving underserved populations.

**Payment and/or Service Delivery Model.**

Pennsylvania has identified four inter-related delivery models and payment methodologies that support delivery system transformation:

1. APOs with shared savings and risk assumption opportunities;

\textsuperscript{4} Patient engagement information is available at: www.alining4healthpa.org/patients.aspx
\textsuperscript{5} http://www.chcs.org/resource/smi-innovations-project-in-pennsylvania-final-evaluation-report/)
\textsuperscript{6} The Massachusetts Hospital Association played a similar role and we will apply its lessons.
2. PCMHs with shared savings opportunities;
3. Episodes of care (EOC) with budgeted reconciled or prospective payments, and
4. Community-based CMT.

APOs, PCMHs and EOCs are all models used in Medicare and increasingly by the State’s insurers, which have indicated their intent to continue to use them in parallel with the State. Each model focuses a provider on systems of care that promote quality of care, prevention and proactive management of chronic conditions, and social determinants of health that influence population health and drive avoidable use of health care services. APOs and PCMHs also promote development of primary care relationships. There is substantial research evidence that suggests that these models, if effectively designed and implemented, can produce improved population health and decreased per capita spending through transformed care delivery.⁷

Pennsylvania’s HealthChoices program promotes selection of a primary care provider as part of a beneficiary’s plan selection and enrollment. In addition, under Pennsylvania’s pending Medicaid 1115 Waiver Demonstration, Healthy Pennsylvania Private Coverage Organizations will require that all newly eligible adults have access to a primary care provider.

The State also intends to implement 50 CMT beginning in SFY15 for the Medicaid population. The CMT will augment care management services provided by PCMHs and other PCPs for patients with complex conditions and social needs. APOs with a high concentration of Medicaid consumers will be expected to establish their own CMT. The CMT will support the PCMHs and increase the opportunity for the practices to earn shared savings. Providers with sufficiently high volume to warrant a dedicated CMT will be offered support to develop their own CMT. Within certain geographies where there are several high-volume providers, the CMT may be run by a qualified community organization.

Pennsylvania anticipates that smaller practices will move to become PCMHs, with only upside savings opportunities, but anticipates that a number of these practices will be part of an APO by the end of the grant period. The State expects that larger practices and health systems that have already developed PCMHs and possess the other necessary infrastructure will develop APOs, enabling even greater financial rewards when they assume downside risk. Hospitals, specialists and PCPs will also have opportunities to align services under optional EOC initiatives.

In addition Pennsylvania intends to pilot four additional reforms to address other elements of the care continuum, with the potential to expand after evaluation of effectiveness:

- use pharmacists to provide patient counseling to conduct medication reconciliation, increase medication adherence, reduce unnecessary poly-pharmacy, and improve transitions of care. Pharmacists may be placed on CMTs and in high-volume community health centers;
- test the CDC evidence-based Diabetes Prevention Program through grants to YMCAs and other community centers, specifically for Medicaid beneficiaries;
- hire registered nurses to join county mental health teams to enhance integration, and
- create mobile, multi-disciplinary community care teams to provide interventions for people with high physical and/or behavioral health needs in settings where consumers live.

The State anticipates adding initiatives focused on LTC based on recommendations expected in December 2014 from Governor Corbett’s Long Term Care Commission. Following the Plan-Do-Study-Act model, each initiative will be developed, implemented, evaluated, adjusted, and if results so indicate, spread. To encourage continuous innovation, the State will also set aside a small portion of the SIM funds for new provider initiatives, including LTC projects that promote innovation.

To promote greater adoption of the APO and PCMH models, the State will utilize its health care coverage programs – Medicaid, CHIP and the pending 1115 Demonstration – to help drive system transformation. DPW, through its contractual relationship with the HealthChoices MCOs and Healthy Pennsylvania Private Coverage Organizations, will drive system transformation by incentivizing approaches tied to quality, outcomes-based performance measures. Development of APO and PCMH models within these programs is a priority in DPW’s effort to encourage greater adoption of innovative commercial market practices. As part of this effort, **DPW will hold contracted insurers accountable for advancing alternative payment models including**
APOs and PCMHs in order to drive outcomes-based performance. In Years 1 and 2, DPW will advance its value-based payment models with the Medicaid managed care and new waiver eligible population. In Year 3, these initiatives will be expanded to dually-eligible consumers, including aging waiver participants.

In addition, the Pennsylvania Employee Benefits Trust Fund (PEBTF), an independent state organization, will promote the development of PCMHs and APOs by setting transformation targets for its health plans as part of its upcoming 2014 procurement process.

Together, by the end of 2018 these reforms are forecasted to serve 1,348,859 Medicaid/CHIP beneficiaries, 531,616 Medicare beneficiaries, 273,181 newly eligibles and 5,222,068 commercial covered lives, representing 53% of Pennsylvania residents. Pennsylvania anticipates that 2000 primary care, behavioral health, and long term care practices and all APOs will be involved in transformation activities.

To ensure coordination, the State will regularly survey public and private payers on payment reform activity and convene them annually to discuss cross-cutting payment reform issues.

Leveraging Regulatory Authority

Pennsylvania will use its regulatory authority and other state policy levers to effectively support and further delivery system transformation. First, the State will use its regulatory authority to address several policy issues in support of our Model Test initiative. DOH has reviewed its existing regulations to identify where there are opportunities to improve the health care delivery transformation and to better coordinate care across the continuum, including opportunities to modify licensing requirements (e.g. telemedicine). DPW will review its telemedicine policy to seek expansion from the current physical and behavioral health outpatient sites of services to other potential areas such as inpatient services, emergency departments, long term living facilities, and community based waiver providers. In addition, the State will work with stakeholders to develop solutions to allow for increased exchange of clinical information, particularly in the area of behavioral health, given the federal and state regulatory framework, for the purposes of improving clinical care.
Second, State purchasers will use contracting authority to emphasize value-based purchasing and provide appropriate incentives for delivery system transformation, as described above. DPW and the Insurance Department will monitor and meet regularly with Medicaid and commercial plans providing coverage to CHIP beneficiaries and newly eligibles to assess progress towards transformation goals and actively work to remove barriers. Within HealthChoices, DPW will start to align pay-for-performance measures so that both the physical and behavioral health MCOs share common quality parameters, including preventable readmissions.

Third, the State will continue to leverage PHC4, which will support data collection and reporting on a statewide basis for SIM initiatives. As Pennsylvania begins to more actively collect and analyze clinical data and share it with consumers, providers and payers, PHC4’s credibility will help advance the effort. Finally, the State remains committed to continuing its successful role as a convener to facilitate multi-stakeholder discussions and thereby develop consensus approaches to advance health system transformation, including the development of a consensus core measure set to report on and track transformation progress.

**Health Information Technology (HIT)**

A strong HIT infrastructure that allows health information to be shared among clinicians facilitates access to care and patient engagement, and supports objective, valid and reliable performance measurement and reporting is essential to the delivery system and payment models described above. Pennsylvania will leverage SIM to: 1) **further strategic collaboration among State agencies** by developing a unified HIT strategy; 2) **significantly increase use of HIT** by providing incentives and technical assistance to providers in rural areas, providers with high Medicaid volume and those not eligible for Meaningful Use incentives to adopt electronic health records (EHRs), connect to a regional health information exchange (HIE), and use telemedicine as appropriate; 3) **streamline the flow of information** by helping providers efficiently report and access performance data; and 4) **inform performance improvement and accountability** through implementation of analytical tools and dissemination of performance data.

Pennsylvania has made great strides in infrastructure development and has advanced broad-based EHR adoption and Meaningful Use by health care providers. The Pennsylvania eHealth Partnership Authority has worked to further connectivity through HIE adoption by Meaningful
Use providers. Further, PHC4 has been a leader in collecting, analyzing and reporting health care data to inform improvements in care delivery. Governor Corbett’s telemedicine initiative furthers the use of HIT to improve access to care. Our Model Test initiative leverages these activities and associated federal and state funding and accelerates their development.

*Governance and Strategic Collaboration:* To ensure statewide strategic alignment, the State will appoint an **HIT Coordinator** within the Governor’s Office of Administration who will be responsible for governance and implementation of the State’s coordinated health information strategy and will work closely with agencies to ensure ongoing alignment. An HIT Executive Committee, chaired by the HIT Coordinator and made up of senior staff designees from DOH, DOA, DPW, the Office of Administration, the eHealth Partnership Authority, and PHC4, as well as consumer representatives, health insurers, and provider organizations, will **develop a coordinated state HIT strategy** in the pre-implementation year. The focus will be on implementing an interoperable HIT and data infrastructure plan to unify and align the HIT plans of each state entity, leverage federal IT funding, and make explicit links between the HIT strategy and its support of population health, delivery system and payment reform. The HIT Executive Committee also will address prioritization and other alignment issues related to data sharing and will develop related HIT policies for adoption by state agencies. The eHealth Partnership Authority has developed standardized data sharing agreements to be used by providers connecting to regional HIEs. The HIT Executive Committee will build upon this work to advance the sharing of protected health information within current state and federal law.

*Infrastructure:* Through the eHealth Partnership Authority, the State is **building a secure bridge to connect its regional HIEs** and allow health care providers with EHRs to transmit health records to other providers. Through the eHealth Partnership Authority’s Pennsylvania Patient and Provider Network (“P3N”), the State hosts a provider directory, patient index, opt-out registry for patients, and a record location service that enables providers to query what records exist for a specific patient and retrieve records in near real time. A separate node to the P3N infrastructure is the **Public Health Gateway** (the Gateway), which provides provider connectivity to DPW and DOH. When fully operational, the Gateway will link the State’s public health registries, surveillance and chronic disease systems, Meaningful Use Clinical Quality Measures (CQM) and EHR incentive data with the P3N to allow providers to report population
health information to the State through regional HIEs. The Gateway will also allow participating providers to report immunizations, laboratory values, cancer cases, and syndromic surveillance to DOH. In 2015, DPW intends to pilot with high-volume Medicaid providers the electronic extraction and reporting through the P3N of several patient level CQMs such as blood pressure values, HbA1c values, BMI values, LDL cholesterol values, and smoking status. SIM will enable PHC4 to be connected into the P3N through the Gateway, enabling meaningful analysis and distribution of information to providers, consumers and the State. Additionally, through use of SIM funds, the eHealth Partnership Authority will enable bi-directional data flow for the Gateway, enabling providers to query for and receive data from State registries and data repositories. This will assist providers by potentially giving a more complete patient health history, which may impact patient care. As the state-facilitated Performance Measurement Workgroup further prioritizes the key core quality measures to be tracked, electronic extraction and reporting of these measures will optimize the timeliness and efficiency of quality reporting.

Pennsylvania has embraced the Meaningful Use Incentive Program. As of April 2014, 42% of PCPs and 53% of acute care hospitals have certified EHRs in use. High-volume Medicaid providers have impressive levels of EHR adoption. As of July 15, 2014, 5,186 high volume Medicaid providers had received EHR program incentives and 2,300 were meaningfully using federally-certified EHRs. Of the 136 eligible hospitals, 124 have received Medicaid incentive payments for meeting the Meaningful Use requirements. As of July 15, 2014, DPW had disbursed over $286 million dollars in EHR program incentive payments to professional and hospital providers. Likewise, Medicare has provided Meaningful Use incentive payments to over 14,000 physicians and 147 hospitals in Pennsylvania. DPW estimates that approximately 1 million unique Medicaid consumers (45%) are being supported by providers and hospitals that now have certified EHR technology. The State will incentivize EHR adoption and connection to regional HIEs by rural providers, who continue to have low adoption rates, and to behavioral health providers and long-term care providers who have not previously had access to incentive funding. Pennsylvania will seek technical support from the Office of the National Coordinator for Health IT in the development of our plan to expand EHR adoption and connectivity for rural providers and other additional providers. Also, DPW will begin to merge

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8 Physician numbers indicate payment made through June 9, 2014; hospital numbers reflect payments made through March 31, 2014.
encounter data from behavioral health MCOs (minus protected substance use data) with
encounter data from HealthChoices MCOs and share these data with its contracted and
subcontracted MCOs, APOs, PCMHs and CMTs.

PHC4 has extensive experience working with data and data-derived initiatives from multiple
sources, including CMS, AHRQ, DPW (Medicaid payment data), DOH, other state agencies, and
Pennsylvania commercial and managed care insurance plans. Currently, PHC4 aggregates
inpatient hospital claim and laboratory data and ambulatory/outpatient procedure data received
from hospitals and free-standing ambulatory surgery centers on a quarterly basis. PHC4 will
continue to collect, analyze and disseminate these data and expand available data to include
emergency department (ED) visits and develop APO- and PCMH-specific reports to assist these
providers with their utilization management and cost management. **Enhancing PHC4’s data
aggregation, analysis and distribution capabilities** is foundational to providing key
standardized measures and information to providers and consumers in support of the delivery
system transformation goals. The data will be used, for example, to determine by APO and
PCMH potentially preventable ED visits, inpatient admissions and readmissions, and the
economic costs associated with those visits and admissions and readmissions. Data, and
supporting analytic tools will be available to providers through a web portal and allow for
performance comparison on standardized measures to internal state benchmarks generated by
PHC4, and to regional and national benchmarks (when available). Stakeholders will be able to
access provider-level data in standardized reports through the same web portal. In addition to
receiving Meaningful Use CQMs for Medicaid providers, the State will ask Medicare-eligible
providers to submit their CQM data to PHC4, as well as to CMS. All PCMHs and APOs will
submit clinical data-based core measure set measures. Health insurers will be asked to submit
data at the APO and PCMH level for the claims-based core measure set measures.

To enhance the State’s telemedicine strategy, the state will **form an Office of Telemedicine**
within the DOH. The Office will initiate a planning process to increase access and timeliness of
care, particularly in the State’s rural areas. Telemedicine resources currently exist to varying
levels in areas such as stroke care, burn care, pediatrics, behavioral health, and long-term care.
Medicaid covers telemedicine in certain provider settings and plans to expand the scope of its
current policy to additional sites of service, including long-term care facilities, behavioral health
providers and community-based waiver service providers. Pennsylvania will significantly **enhance its telemedicine infrastructure** by focusing on expanding the number of “spokes” that are connected to “hubs” that provide the specialty services. The State will work closely with its Telemedicine Advisory Board to define needs and gaps in care by geographic area, regulatory needs, and how to pay and bill for telemedicine services. The State will also provide grants to build the necessary linkages between the new “spokes” and the appropriate “hubs.”

**Stakeholder Engagement**

Pennsylvania keenly understands the importance of stakeholder engagement in delivery system transformation. Since the formation of its CCI in 2008, the State has worked to convene public and private payers to develop and implement delivery system reforms across the state. *Provider and insurer representatives have lauded the State for its role in convening and facilitating meaningful change.* Due to this experience, we have positioned stakeholder engagement as the backbone of all the work we are doing to transform the delivery and payment systems under our State Health Innovation Plan and this Model Test Application which would allow us to implement our Model. The State can convene and lead, but to be successful and for change to occur it requires the active partnership of supportive stakeholders with a shared vision of transformation.

As part of the development of the SIM Health Innovation Plan, Governor Corbett invited over 250 stakeholder organizations from across the state to participate in one of seven workgroups to help inform the State of ongoing initiatives, opportunities and barriers within the health delivery system and to provide direction for the Innovation Plan. Pennsylvania brought together, between June 2013 and September 2013, nearly 300 stakeholders from the health care industry in the state, including payers, providers, physicians, nurses, hospital leaders and associations, to formulate seven workgroups focused on specialties including care delivery models, (with a pediatric subgroup), payment methodologies, performance measurement, information technology infrastructure, workforce development, and public health integration. Stakeholders included consumers, foundations, insurers and MCOs, Behavioral Health MCOs, professional associations, providers, public health entities, unions, quality assurance organizations, drug and alcohol entities, aging and long-term care organizations, elected officials, community organizations, academia and government agencies. These stakeholders collaborated in 19
meetings with the DOA, DOH, DPW, the Department of Insurance, the e-Health Authority and Governor Corbett’s office.

The resulting Health Care Innovation Plan, submitted to CMMI in December 2013, reflects the collective thinking of the State on how to transform the health care delivery and payment systems in order to obtain better health for our citizens, better health outcomes individually, and reduce cost growth over the long term. More recently, stakeholders played an important role in the development of this Model Test Application. The Secretary of Health and Insurance Commissioner held update calls with stakeholders and sent email messages to keep stakeholders informed. In addition, the DPW was in communication with its stakeholders, including its contracted MCOs. Additionally, face-to-face meetings were held with key stakeholder organizational leaders, as well as with selected professional associations.

Stakeholder engagement will continue to be paramount as we move towards implementation upon being awarded a Model Test Grant. Stakeholders will play a key role in the governance of the Grant, including participation of consumer, provider, insurer and employer representatives on the SIM Executive Committee. Given the importance of the HIT strategy for transformation, stakeholder representatives will also participate in the HIT Executive Committee. Another larger community of stakeholders will be engaged through their participation on an active SIM Advisory Committee and subcommittees which will be composed of representatives from providers who are providing services across the health care continuum, employers, organized labor, payers and consumers representing Medicare, Medicaid and commercial populations. Members of the SIM Management Committee will also participate in the Advisory Committee meetings, and applicable sub-committees, in order to get first-hand stakeholder feedback on the progress and direction of particular components of the Grant. The Advisory Committee will be co-chaired by an executive branch agency representative and a stakeholder, with leadership changing annually. The Advisory Committee will provide input into all aspects of the SIM project via an array of subcommittees working on specific topics or by integrating existing groups into the SIM project. Two examples of subcommittees to be formed include a Transformation Center Advisory Committee and the Performance Measurement Committee. In addition, we will leverage existing advisory groups to serve in this capacity, including the Telemedicine Advisory Board.
As described in Part i.2 above, a centerpiece of our Model Test proposal is the development and implementation of a Transformation Center which will be a key vehicle for promoting stakeholder participation, including individual providers, APOs, social service providers, public health programs and payers. The Transformation Center will provide a statewide platform from which to provide ongoing outreach and education and continued engagement to stakeholders to participate in the transformation of the delivery system, with a particular, but not exclusive, focus on providers across the continuum of care. The Transformation Center will partner with key provider associations, including the Pennsylvania Medical Society and the Hospital and Healthsystem Association of Pennsylvania to communicate the pressing need for transformation, publicize the Transformation Center, and also provide direct technical assistance.

**Quality Measure Alignment**

Pennsylvania recognized that objective, valid and reliable measurement of performance is essential to the success of our delivery system transformation activities. In Pennsylvania, as elsewhere, there continues to be variation in the data sets used by payers that adds administrative complexity for providers, and makes it difficult to assess performance across payers’ member populations. This problem of varying measure sets was a major point of discussion by Pennsylvania stakeholders within the SIM Performance Measurement Workgroup. Provider organizations spoke passionately to the large numbers of measures for which they are being held accountable, and in some cases, being asked to report. There was strong consensus among payers and providers that an aligned set of performance measures for APOs and a related one for PCMHs would increase the likelihood that each type of entity would be able to focus on high priority areas of performance where opportunities for improvement exist. In addition, alignment may reduce provider and insurer administrative costs created by disparate measure sets. Additionally, there is a need to leverage the use of EHR extraction and health information exchange to measure quality more efficiently and quickly to assure rapid time quality improvement.

**Pennsylvania stakeholders have agreed to discuss the adoption of a core measure set as part of its Test Model.** To that end, the State created a crosswalk of the existing measure sets from which measures will be drawn to create an initial Pennsylvania core measure set.
Pennsylvania plans to expand the Core Measure Set in Year 3 to include measures related to long-term care services and measures specific to consumers with disabilities.

Major delivery systems, and commercial and Medicaid payers representing a majority of Pennsylvania covered lives, have agreed to participate in a state-facilitated process to finalize a core measure set. Core measures initially will be drawn from most of the following domains: 1) continuity and care coordination, including transitions of care measures; 2) clinical quality, preventive care, including essential screenings, immunizations and well-care visits measures; 3) clinical quality, chronic illness, including asthma, cardiovascular disease, diabetes, hypertension, and medication management measures; 4) clinical quality, acute care, including overuse, avoidable admissions, patient safety, and maternal health; 5) clinical quality, mental health and substance use care; 6) patient experience and patient engagement; 7) health status; 8) cost; 9) health disparities and 10) social, economic and behavioral determinants of health. The domains and associated measures will be expanded for Year 2 to include initial omissions, and then again for Year 3 to include measures related to the provision of long-term care services and services specific to consumers with disabilities in order to capture the spread of the Test Model to dually-eligible consumers.

To assure alignment with population health goals and the parallel and supporting public health activities led by the DOH, the measures will include key indicators to track diabetes, tobacco use, obesity, ADRD, and oral health. Wherever possible, measures will be drawn from national measure sets, including HEDIS, CMMI Core Measures, and MSSP measures. We anticipate that the initial core measurement set for Year 1 will be finalized during the first eight months of the pre-implementation year.

The core measure set will be developed with twin objectives of a) focusing providers and communities on key population health priorities and b) aligning APO and PCMH contractual incentives on population health (and other) measures. These data will be collected and reported by PHC4 and used by providers, payers and the Transformation Center to identify gaps and implement targeted initiatives to close the identified gaps. The data will also be used by DOH to evaluate its public health initiatives and make adjustments to increase their impact.
The CCI has shown that sharing comparative performance information with providers and defining improvement expectations specific to a provider’s own performance can energize change and transformation. Similar to the State’s role in overseeing the implementation of the CCI, the State will serve as convener of a consensus-driven process to develop consistent reports, initially focusing on standard care plans, high risk patient lists, and gaps in care reports. The State will also work with stakeholders to develop a strategy to ensure consistent measurement of patient experience across APOs.

PHC4 will be creating practice-based and APO-based reports that will be available to providers, payers, consumers and the Transformation Center. There will be opportunities for providers to compare their performance with that of their peers and against national benchmarks, where available. The Transformation Center will use the data to identify areas of needed skill development and develop targeted training sessions as well as practice facilitator interventions for targeted practices and APOs that are struggling more than most.

Alignment of performance measures will not in and of itself reduce spending. It will, however, allow focus on potentially impactful opportunities for improvement such as reducing avoidable hospital admissions, readmissions and ED visits that can lead to decreased per capita health care spending.

**Monitoring and Evaluation Plan**

The state-based evaluation of the PA Model Test will be carried out by a team of researchers from the Institute for Evaluation Science of the University of Pittsburgh’s Graduate School of Public Health, led by Dr. Edmund Ricci (Director of the Evaluation Institute), Dr. Mary Hawk (Associate Director of the Institute), and Professor George Huber, who serves as Associate Dean of the Graduate School of Public Health and as faculty. The staff of the Evaluation Institute has a long history of conducting evaluations of public health and medical programs and initiatives.

The evaluation team will assess both formative/process indicators and quantitative measures. By providing bi-monthly updates to the SIM Program Director and Management Team and for presentation to the SIM Executive Committee and Advisory Board, the evaluation team will provide a feedback loop to anticipate and/or identify barriers to the implementation so that these
may be promptly addressed. Since process and outcome indicators will be followed in tandem
the evaluation team will also assess the effectiveness of policy and regulatory levers applied
under the Model Test.

The observational and interview components will follow accepted methods for scientific
“process analysis.” The observation guides and interview schedules will be semi-structured.
Triangulation methods will be used to validate important findings. Analysts will meet bi-weekly
with the Evaluation Leadership Team to review and summarize findings. Mr. Huber and Drs.
Hawk and Ricci will provide bi-monthly briefings with the SIM Management Team.

The outcome evaluation will address the question: To what extent were the short, intermediate,
and long-term outcomes achieved? The overall outcome evaluation is based upon time series
data for the target populations. The purpose of this effort will be to focus upon those targets
specified in the Model Test application and refined through discussion with CMMI.

The evaluation team will work closely with PHC4 staff to coordinate activities and share data.
As noted elsewhere, PHC4 will be collecting specified data to be used to track SIM outcomes.
PHC4 will share these data with the evaluation team, which will organize data from all sources
into comprehensible reports for the SIM Management Team.

In collaboration with the SIM Management Team, the evaluation team will work closely with
CMMI’s evaluation vendor to finalize the measures for the three key outcomes of strengthening
population health, transforming the health care delivery system and decreasing per capita health
care spending and to provide requested data throughout the initiative. Based on the proposed
Model Test, the following measures and targets have been selected. In addition to the leading
indicators listed below, the evaluation team will also assess performance relative to the measures
contained in the broader SIM common measure set.

<table>
<thead>
<tr>
<th>SIM Evaluation Measure</th>
<th>Performance Improvement Targets</th>
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<tbody>
<tr>
<td><strong>Population Health</strong></td>
<td></td>
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<tr>
<td>Tobacco Use (BRFSS)</td>
<td></td>
</tr>
<tr>
<td>1. Four-level smoking status for PA</td>
<td>Baseline data source: BRFSS 2011</td>
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<tr>
<td></td>
<td>1. Reduce by 2018:</td>
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<tr>
<td></td>
<td>Smoke everyday: 15.7% to 13.5%</td>
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<tr>
<td>SIM Evaluation Measure</td>
<td>Performance Improvement Targets</td>
</tr>
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<td>------------------------</td>
<td>--------------------------------</td>
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<tr>
<td>2. % of adults who smoke who quit smoking at least 1 day in past year</td>
<td>Smoke some days: 5.7% to 5.3%</td>
</tr>
<tr>
<td></td>
<td>Former smoker: 25.5% to 26.2%</td>
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<tr>
<td></td>
<td>Never smoked: 53.2% to 55.0%</td>
</tr>
<tr>
<td>3. Current smoker – every or some days</td>
<td>2. Increase from 55% to 61.5%</td>
</tr>
<tr>
<td>4. Smokeless tobacco use</td>
<td>3. Reduce from 21.4% to 18.8%</td>
</tr>
<tr>
<td>5. Disparity between racial, ethnic and income groups compared to other groups: Current Smokers</td>
<td>4. Reduce from 4% to 2.9%</td>
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<tr>
<td></td>
<td>5. Reduce health disparities</td>
</tr>
<tr>
<td></td>
<td>Black, non-Hispanic: reduce from 28% to 26.6%</td>
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<tr>
<td></td>
<td>Household Income:</td>
</tr>
<tr>
<td></td>
<td>$25,000 to 49,999: reduce from 23% to 20.8%</td>
</tr>
<tr>
<td></td>
<td>$15,000 to 24,999: reduce from 28% to 24.8%</td>
</tr>
<tr>
<td></td>
<td>&lt; $15,000: reduce from 38% to 32.8%</td>
</tr>
<tr>
<td>6. % of high school students who smoked cigarettes in past 30 days</td>
<td>6. Reduce from 18.4% to 16.8%</td>
</tr>
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</table>

**Obesity (BRFSS)**

<table>
<thead>
<tr>
<th>SIM Evaluation Measure</th>
<th>Performance Improvement Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. % of adults over 18 considered overweight (BMI 25.0-29.9)</td>
<td>Baseline data source: BRFSS 2011</td>
</tr>
<tr>
<td>2. % of adults over 18 considered obese (BMI 30.0 – 99.9)</td>
<td>Reduce by 2018</td>
</tr>
<tr>
<td>3. % of students who were &lt;=95th BMI</td>
<td>1. reduce from 36% to 32%</td>
</tr>
<tr>
<td>4. Disparity between racial, ethnic and income</td>
<td>2. reduce from 29% to 25%</td>
</tr>
<tr>
<td></td>
<td>3. reduce from 11.7% to 9.3%</td>
</tr>
<tr>
<td></td>
<td>4. Reduce health disparities:</td>
</tr>
<tr>
<td></td>
<td>Black, non-Hispanic: reduce from 35% to 33.6%</td>
</tr>
<tr>
<td></td>
<td>Household Income:</td>
</tr>
<tr>
<td></td>
<td>$25,000 to 49,999: reduce from 32%</td>
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</table>
## SIM Evaluation Measure

<table>
<thead>
<tr>
<th>SIM Evaluation Measure</th>
<th>Performance Improvement Targets</th>
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<tbody>
<tr>
<td></td>
<td>to 30.2%</td>
</tr>
<tr>
<td></td>
<td>$15,000 to 24,999: reduce from 34% to 31.8%</td>
</tr>
<tr>
<td></td>
<td>&lt; $15,000: reduce from 35% to 32.6%</td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
</tr>
<tr>
<td>1. % of adults with diabetes having four A1c Tests in the last year</td>
<td>Baseline data source: BRFSS 2012</td>
</tr>
<tr>
<td>2. % of adults with diabetes receiving a foot exam in the last year</td>
<td>• increase from 30% to 34.4%</td>
</tr>
<tr>
<td>3. % of adults with diabetes receiving a dilated eye exam in the last year</td>
<td>• increase from 77% to 81.4%</td>
</tr>
<tr>
<td></td>
<td>• increase from 71% to 75.4%</td>
</tr>
<tr>
<td>Dementia</td>
<td>1. Reduce percent by 20% in 2018</td>
</tr>
<tr>
<td>Oral Health</td>
<td>Baseline data source: BRFSS 2015</td>
</tr>
<tr>
<td>1. Percentage of children under 5 years of age with no cavities</td>
<td>1. Achieve goal of 60% by 2018</td>
</tr>
</tbody>
</table>

## Per Capita Cost Spending

<table>
<thead>
<tr>
<th>Per capita inpatient costs (CMS, DPW and commercial insurers)</th>
<th>Baseline data source: CMS, DPW and commercial insurers for 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Medicare</td>
<td>1. constrain the annual rate of increase for Medicare, Medicaid and commercial to CPI-U+2% or less by 2018</td>
</tr>
<tr>
<td>2. Medicaid</td>
<td></td>
</tr>
<tr>
<td>3. Commercial</td>
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## Delivery System Transformation

<table>
<thead>
<tr>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
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<tbody>
<tr>
<td>Population-based Contracting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>APO contracting targets (percent of membership receiving services from providers under APO population-based payment contracts)</td>
<td>Commercial: 14.0%; Medicare: 7.5%; Medicaid: 6.3%; CHIP: 7.5%; Newly eligibles: 0.0%</td>
<td>Commercial: 20.9%; Medicare: 11.2%; Medicaid: 9.4%; CHIP: 11.2%; Newly eligibles: 11.2%</td>
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</tr>
<tr>
<td>APO contracting rates (percent of membership receiving services from providers under APO contracts accepting upside and downside risk)</td>
<td>Commercial: 5%; Medicare: 2%; Medicaid: 2%; CHIP: 5%; Newly eligibles: 0.0%</td>
<td>Commercial: 5%; Medicare: 5%; Medicaid: 5%; CHIP: 5%; Newly eligibles: 5%</td>
</tr>
<tr>
<td>PCMH contracting targets (percent of primary care practices attaining a specified level of PCMH skills as measured by a validated tool)</td>
<td>30% statewide</td>
<td>45% statewide</td>
</tr>
<tr>
<td>Primary Care Providers</td>
<td>% of primary care practice sites submitting core measurement data to PHC4</td>
<td>• 10%</td>
</tr>
<tr>
<td>Care Management</td>
<td>Community-based Care Management Teams</td>
<td>33%</td>
</tr>
<tr>
<td></td>
<td>• % of DPW high-risk patients engaged in care management</td>
<td></td>
</tr>
<tr>
<td>Telemedicine</td>
<td>% of rural population within 30 minutes of telemedicine site</td>
<td>To be determined based on environmental scan completed in pre-implementation year.</td>
</tr>
</tbody>
</table>
% of urban population within 30 minutes of telemedicine site | To be determined based on environmental scan completed in pre-implementation year.

<table>
<thead>
<tr>
<th>EHR Adoption in Rural Counties</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of office-based providers with operational EHR</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider Connection to Regional HIE</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of targeted providers connected to HIE</td>
</tr>
</tbody>
</table>

Alignment with State and Federal Innovation

Our Application aligns with several existing state and federal innovations supportive of the payment and delivery strategies in the Innovation Plan, as well as the state’s pending 1115 Demonstration Waiver. A listing of some of these efforts follows below. **We commit to not use any SIM funds to support these efforts to the extent they continue during the grant period.**

- CMS’ Medicare’s Coordinated Care Demonstration (Health Quality Partners)
- CMS’ CMMI Innovation Grant (PRHI)
- CMS’ Integrated Care for Populations and Community (Quality Insights)
- CMS’ Community-based Care Transitions Program (CCTP) (six counties)
- CMS Partnership for Patients, Hospital Engagement Network. (The Hospital and Healthsystem Association of Pennsylvania)
- Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration. (Commonwealth of Pennsylvania)
- DOH support for developing PCMHs to provide services to children with special needs.

Our Transformation Center will leverage this ongoing work in its dissemination of best practices to APOs, PCMHs and other providers, and will ensure learning and engagement occurs at both a statewide and local level. Specifically, we will a) incorporate curricula from these programs, and best practices identified during their implementation, into the Transformation Center’s offerings,
b) utilize experts from these programs as advisors and faculty for the Transformation Center’s offerings, as well as advisors to the initiative more broadly, and c) create formal mechanisms by which these initiatives convey their activities and findings to the SIM Management Committee and the Transformation Center on a regular basis.

Budget Narrative

To transform its delivery system to population-based payment and delivery models, Pennsylvania is using public and private resources to promote patient-centered medical homes and accountable provider organizations, episodes of care, and community-based care teams (for high-risk Medicaid beneficiaries). To support delivery system transformation, Pennsylvania is strengthening its HIE, seeking to implement a unified set of performance measures, enhancing its data collection and reporting capabilities, expanding telemedicine infrastructure, creating a sophisticated Transformation Center to provide evidence-based technical assistance to provider practices and APOs, and developing and implementing a state health improvement plan.

A. State Agencies and Affiliated Organizations

The Department of Health (DOH), Center for Practice Transformation and Innovation (CPTI) will be responsible for overseeing the administration of the SIM grant and implementing six major SIM initiatives. To oversee the SIM grant, the CPTI will dedicate to SIM 100% of the time of the Director and of the current grant manager over the four-year grant period. In addition CPTI will hire an HIT Coordinator who will sit within the Office of Administration to develop and implement the statewide HIT strategy, a financial director to manage SIM funds, a financial coordinator to assist the financial director, three budget analysts to assist the financial director, a director of report compliance to assure that all CMMI reporting requirements are met, a reporting coordinator to assist with CMMI reporting requirements, an administrative office manager to oversee the operations of the CPTI and meeting planning, three executive assistants to assist the Grant Director, the Grant Manager and the HIT Coordinator to support the work of the CPTI, two administrative officers, an administrative coordinator to assist with contract monitoring and three Public Health Program Administrators responsible for overseeing the models of the transformation center and the SHIP implementation. CPTI has also budgeted funds to administer a grant program to support innovation by providers, provider organizations, and providers working in partnership with payer or community partners. Specific criteria and application
process will be finalized during the pre-implementation year. CPTI will be obtaining consulting support for strategic planning and project management and to implement the Transformation Center, which is discussed in the Contractor section of the Budget Narrative.

**The Loan Repayment Initiatives** will be administered by the DOH’s existing staff. SIM funds will be used to revise a web-based loan repayment application and to fund loan forgiveness for 80 providers over a three-year period. This program expands loan repayment opportunities to new populations that are not included in current loan repayment programs.

The Pennsylvania Chapter of the Academy of Pediatrics will designate a program director and a program coordinator for the first three years of the grant to oversee the oral health initiative, this program will target the primary care providers, the prenatal, obstetric providers and dental providers.

To implement the telemedicine expansion DOH will create a new Office of Telemedicine and hire a director, one program administrator, a budget analyst, an administrative officer and clerical support. Grants to expand telemedicine will be available to hospitals, primary care practices, long-term living facilities and behavioral health providers. The Office of Telemedicine will also be obtaining consulting assistance as discussed in the Consultant section of the Budget Narrative.

One key SIM initiative is the implementation of the local State Health Improvement Plan, which will be overseen by CPTI with the assistance of consultants.

The DOH over a four-year period will hire eight new staff to administer the expansion of the population health initiatives, including a project manager, two program administrators, an administrative officer, a health communications specialist, two education field staff, and a health economist. To expand several of the population health initiatives, DOH will continue their contracts with two organizations. **Penn State University, Center for PRO Wellness**, which has a mission to educate and inspire youth and their families to eat well, engage in regular physical activity and become champions for bringing healthy choices to life, will administer the expansion of the school nutrition and physical activity program to 100 targeted schools. The initiative will increase the number of diabetes self-management education sites and will be administered by the Health Promotion Council, a Philadelphia-based organization whose mission is to promote health, prevent and manage chronic diseases, especially among vulnerable populations through community-based outreach, education and advocacy.
The DOH will be using SIM funds to connect to the Public Health Gateway so that providers will be able to report and access immunization and other public health data.

The Pennsylvania Department of Aging (DOA) will be working with the PA Alzheimer’s Association Chapters to implement an information and referral system for ADRD patients, caregivers and providers. The information and referral center will be developed and staffed by consultants.

The Pennsylvania Department of Public Welfare will be providing in-kind support of the SIM initiative by dedicating leadership and other departmental staff resources to changing reimbursement and delivery systems from FFS to population-based models and to oversee the implementation of the community-based care management teams. DPW has also included in its budget to bring on ten consultants to advance the SIM initiative. DPW budgeted additional funds to provide incentives for EHR connectivity in low adoption areas and for HIE connectivity among high volume Medicaid behavioral health and long-term care providers who have generally adopted EHRs, but not HIE connectivity. The specific qualifications and application process will be finalized during the pre-implementation year.

A key Pennsylvania transformation strategy built into the SIM initiative is significantly enhancing the capabilities of the Pennsylvania Health Care Cost Containment Council (PHC4) to collect, analyze and report data on a statewide, as well as PCMH and APO-specific basis for the State, consumers, payers and providers. PHC4’s current capacity is funded by state funds and provider fees, which will continue. To enhance its current capabilities, PHC4 will increase server capacity, database software, a network switch and cabling. PHC4 will also be hiring consultants to support the initiative.

The Pennsylvania eHealth Partnership Authority, using state and grant funding, has been responsible for building the State’s system for integrating regional HIEs and, therefore, is a key partner in enhancing reporting and data-sharing capabilities within the state. The eHealth Partnership Authority is budgeting to enable bi-directional data flow for the Public Health Gateway so that providers may both query for and receive data from State registries and other data repositories that are connected to the Public Health Gateway. The eHealth Partnership Authority will also be utilizing consulting services, discussed in the Consultant section of the Budget Narrative, to provide project management oversight and to assure that technology project requirements are met.
B. Consultant Services

DOH will be utilizing consulting services for the following aspects of the SIM initiative. CPTI will be engaging the services of Pittsburgh Regional Health Initiative (PRHI) to develop and implement the Transformation Center. Currently Pennsylvania offers limited transformation support to practices within two regions of the state, and these support services will end on December 31, 2014. The creation of the Transformation Center will, therefore, be a vital resource to promote provider adoption of population-based payment and delivery system models.

To create and implement the Transformation Center, PRHI will be dedicating a portion of its 17 staff members’ time, including administrative and financial staff as well as content and technical experts for the Transformation Center. PRHI will be subcontracting with yet-to-be identified entities to operate the six regional hubs; provide web design services, EHR support, practice coaches, meeting facilitation and speakers. PRHI anticipates subcontracting with one or more consulting firms for APO training support. In addition, for ease of administration, PRHI will be subcontracting with a consulting firm to provide additional strategic and project management support services to CPTI for the entire SIM project. The PRHI budget also includes “other” services, including PRHI overhead; webinar services; and rental, food and production costs for an annual innovation summit, semi-annual leaning collaborative meetings, 32 APO conferences and quarterly Hub meetings, as well as CME application fees to obtain CME credits for the meetings.

In addition, CPTI will be contracting with Bailit Health Purchasing, LLC, which has been working with Pennsylvania to support the CCI and the two SIM application processes. Bailit will provide strategic, project management and technical assistance for the SIM initiative. Bailit consultants anticipate providing approximately 10.5 hours of services weekly throughout the grant period.

DOH will also be hiring a yet-to-be-determined consultant to provide the on-the-ground administrative and technical support to the six regional SHIP Steering Committees. DOH will be contracting with the PA Chapter of the American Academy of Pediatrics to implement the oral health initiative, including program promotion, education, and enrollment of 1,000 providers, and program evaluation of the impact of the initiative. To create and implement a strategic plan for telemedicine services throughout the State, the DOH Office of Telemedicine will be engaging a yet-to-be-determined consultant to conduct an environmental scan, develop an
RFP process to select new telemedicine spokes, develop performance measures and an evaluation plan, provide technical assistance regarding payment models and structure a long-term care pilot.

To create and run the ADRD information and referral center, DOA will be contracting with an experienced, but yet-to-be-determined entity. The consultants will be developing the framework for the information and referral center, providing call center agents to staff the call-in number, and developing and implementing marketing plan.

To implement its SIM initiatives, DPW is assembling a team of ten experts, including current and new consultants who will focus all or a part of their time on SIM. Members will include two senior medical economists, two health care analysts, a program specialist, a quality nurse consultant, the Medicaid Chief Medical Officer, two registered nurses, and the Office of Long Term Living Director. Team members will focus on meeting contracting targets, overseeing and monitoring the community care management teams, and evaluating the impact of all DPW SIM initiatives.

The eHealth Partnership Authority will be engaging a senior program manager and a senior business analyst to provide technology program oversight, interagency coordination, strategic alignment, vendor liaison and overall project support.

C. System and/or Data Collections Costs and Budget to Collect Data

System and/or data collection costs and a budget to collect data are detailed in the PHC4 and eHealth Authority budgets, discussed above. The State’s evaluator, the University of Pittsburgh, will also be collecting and analyzing expanded BRFSS data.

D. State Evaluator Costs

The University of Pittsburgh’s Graduate School of Public Health, Evaluation Institute (the Institute) will be the state evaluator. The Institute employs experienced evaluators of public health and medical programs, including the PA Chronic Care Initiative. To provide evaluation services, the Institute has assembled a team of seven staff who will be contributing part or all of their time on the SIM initiative, including one principal investigator, two co-principal investigators, two research assistants, one statistician and one policy analyst. The policy analyst will be responsible for managing the collection and analysis of additional BRFSS data. The team members will be traveling throughout the state for various evaluation purposes and anticipate traveling 1,100 miles annually.
Other Grants, Revenues or In-kind Services or Resources

For the purposes of forecasting its operational revenues, Pennsylvania assumes that it will continue to receive its current funding from the various federal agencies that currently provide project and service funding, including the Center for Disease Control and Prevention (CDC) and the Centers for Medicare and Medicaid Services (CMS). The SIM grant will also receive in-kind services from each of the departments, authorities and state-operated entities (e.g., eHealth Authority, PHC4) that will have staff serving on the SIM Executive Committee, the SIM Management Committee and participating on work groups that will be forming or already exist and which will support SIM implementation.

E. Expected or Needed Funding from Other Federal Sources

Pennsylvania’s pending 1115 Demonstration Waiver will allow for federal funding of newly eligibles. DOH receives significant funds for its population health programs and the development of its SHIP through the Center for Disease Control and Prevention. DPW is awaiting a decision on a CMS grant that would fund $2.4 million to support P3N.

F. Attestation

Pennsylvania state government attests that the Innovation Center funding for Pennsylvania’s SIM initiative will not supplant any other funding sources.