



# Issue Brief

## State Innovation Models: Early Experiences and Challenges of an Initiative to Advance Broad Health System Reform

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**ABSTRACT:** The Centers for Medicare and Medicaid Services and states are partnering to transform health care systems by creating and testing new models of care delivery and payment. Interviews with officials from states participating in the State Innovation Models (SIM) Initiative reveal that the readiness of providers and payers to adopt innovations varies, requiring different starting points, goals, and strategies. So far, effective strategies appear to include: building on past reform efforts; redesigning health information technology to provide reliable, targeted data on care costs and quality; and using standard performance measures and financial incentives to spur alignment of providers' and payers' goals. State governments also have policy levers to encourage efficient deployment of a diverse health care workforce. As federal officials review states' innovation plans, set timetables, and provide technical assistance, they can also take steps to accommodate the budgetary, political, and time constraints that states are facing.

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### OVERVIEW

State and federal policymakers recognize that innovations in Medicaid alone cannot hold down health care costs or improve care systemwide. More payers must be involved in efforts to increase health care value. Led by the Innovation Center of the Centers for Medicare and Medicaid Services (CMS), the State Innovation Models (SIM) Initiative provides funding and technical assistance to help states plan, design, and test new service delivery and payment models to advance broad health system reform.

Since launching the initiative in July 2012, CMS has awarded nearly \$300 million to 25 states to design and launch State Health Care Innovation Plans. Grantees include six "model-testing" states, which are moving ahead with their plans; three "model-pretesting" states, which are continuing to design their plans; and 16 "model-design" states, which are creating their plans (Exhibit 1 and

Exhibit 2). The agency expects these states to use these plans to produce significant and measurable improvements in their health care systems.

The SIM states have picked up the gauntlet and are showing their commitment to shake up their health care system by altering payment mechanisms to spur providers to produce better value and improve population health. For example, Arkansas, a model-testing state, is launching episode-based payments statewide, with support from both public and private insurers. Oregon, also a model-testing state, is promoting coordinated care organizations—community-based networks of providers that receive a set fee to provide a range of services to Medicaid beneficiaries, aiming to help them manage chronic illnesses and promote health.

To shed light on the early experiences of these states, we talked with leaders in model-testing and model-design states during meetings in May 2013.<sup>1</sup> These discussions revealed key lessons that can inform work with federal partners in all states as they undertake health system reform.

## RESEARCH FINDINGS

### 1. SIM offers an unprecedented opportunity for states to build on or initiate health reform efforts. Strong leadership from state officials is essential.

SIM grants give states the opportunity to engage significant payers and providers in “harmonic convergence” on health care reform. SIM states with the greatest momentum and clearest vision often have a strong history of promoting reform during both

### Maryland: Model-Design State

Maryland plans to expand its all-payer hospital rate-setting approach to all health care costs. Its goal is to hold growth in overall health care costs below the overall inflation rate in the state's economy.

Republican and Democratic administrations, based on a shared vision among trusted partners. Experience in these states shows that powerful and sustained leadership from the governor and legislative champions is critical. However, even with such leadership, transforming health care is a difficult, long-term proposition. There is no magic bullet.

### 2. Like CMS, SIM states understand that transforming the health system requires collaborating with multiple payers and providers. However, the readiness and capacity of these players to innovate and “align” varies, so engaging them requires different starting points, goals, and strategies.

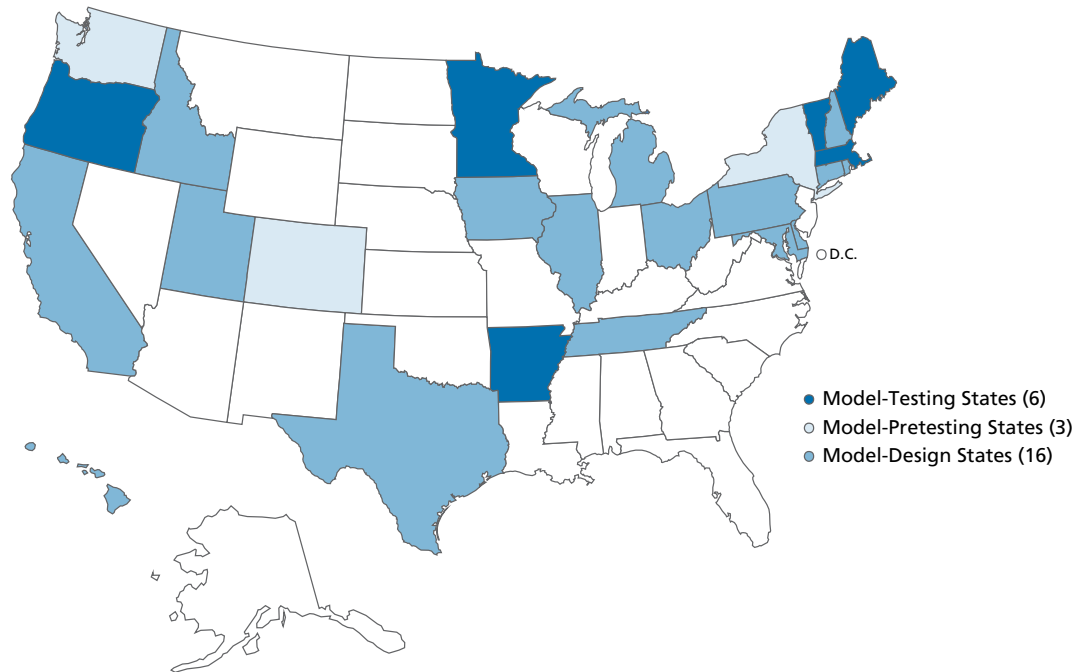
Medicaid alone—or any one commercial insurer—has only limited market power, so engaging multiple payers and keeping them invested in a consensus-building process to align goals for health system reform is critical. Implementing new payment strategies, in turn, requires engaging providers in modifying how they deliver care, measuring their performance, and accepting new approaches to payments for services.

Model-design states are facing challenges in bringing key stakeholders to the table to create reform plans. Several states report that their Medicare contacts

Authorized under the Affordable Care Act, **SIM** is one of several demonstrations and pilots managed by the Innovation Center. These focus on the financial alignment of provider and payer incentives, with the goal of delivering cost-effective, high-value care to patients through multipayer initiatives, accountable care with shared savings, quality improvement, and other reforms.

The six model-testing states receive \$33 million to \$45 million over 42 months to implement their state health care innovation plans. The three pretesting states receive \$1 million to \$2 million over six months to refine their plans. The 16 model-design states receive \$1 million to \$3 million over six months to develop their plans. CMS expects model-design states to apply for an anticipated second round of awards for testing their models.

EXHIBIT 1. STATE INNOVATION MODELS (SIM) INITIATIVE GRANTEES, 2013



Source: Centers for Medicare and Medicaid Services.

seem uninterested in participating in deliberations on new approaches to payment and care. Some commercial payers and health plans resist even thoughtful dialogue on alternative designs for providing and paying for care and ensuring transparency on the quality of care.

Physicians, hospitals, managed-care organizations, employers, and insurers vary in their readiness to adopt new approaches such as bundled payments and accountable care organizations. Many providers are already burdened with a haphazard array of metrics for measuring quality across payers. Providers frequently need technical assistance in improving their performance, including onsite training in coordinating care, measuring quality, and using electronic health records.

#### **Oregon: Model-Testing State**

Oregon is implementing local coordinated care organizations. Its Medicaid contracts incorporate eight levers for change, such as requiring a plan to improve the delivery of care, use alternative payment methods, and offer quality incentives. The state plans to extend this model to health insurance contracts for state employees, and then to private payers.

Many hospitals expect to have trouble filling their beds as insurance coverage and primary care expand, and are wary of new approaches that shift their risks and responsibilities. And providers and health plans in some model-testing and model-design states are reluctant to collaborate because they fear losing competitive advantage or violating antitrust rules.

Because Medicaid payments to providers are often far lower than payments from Medicare and commercial payers, Medicaid officials in some states are also uncertain about how to partner with payers to produce savings.

However, different levels of payer and provider readiness to collaborate should not deter state Medicaid agencies from using their leverage and market power to push for change.<sup>2</sup> These agencies can begin by partnering with state employees and retirees, and local public employees, on strategies for transforming the health care payment system. States are also finding that they can enlist large, self-insured employers concerned about health costs and quality in developing new payment and care models.

States can similarly find ways to encourage providers to participate in reform, such as by

**State challenges in designing strategies for improving the performance of the health care system:**

- Difficulty defining core quality measures and attaining payer agreement on them.
- Disagreements on which entity should control performance data.
- Privacy concerns, particularly regarding certain populations and services, such as mental health.
- Uncertainty about what financial incentives may be necessary for providers and payers to share information.
- Technical challenges and culture changes related to value-based models that link medical records, clinical information, and administrative data from different providers (with different ID numbers) for each patient.

facilitating data exchange, providing customized reports on providers' utilization, costs, and/or quality trends, and improving providers' experiences with large payers. Research and experience suggest that states can reduce the burden on providers by standardizing performance measures and reporting requirements. These reforms ease administrative complexities and allow providers (as well as payers and other stakeholders) to combine and compare data across payers and initiatives.

Several state officials recommend creating a provider workgroup to develop standard metrics for measuring the quality of care. Guidance being developed to help accountable care organizations and multipayer initiatives adhere to antitrust law should help states and their partners overcome legal concerns about such collaboration.<sup>3</sup>

For their part, state planners are struggling to find the right balance between standardization and flexibility. They know they must engage a range of players, but are unclear about the extent to which they can or should align incentives, payment models, and performance measures. They are learning that identical rates, metrics, and strategies are not essential. Instead, states can reduce the cost and improve the quality of care simply by establishing “guardrails” to reduce variations across payers. Experiences and studies also

suggest that states should seek tight guardrails on performance metrics, but greater flexibility in payment approaches, to account for variations in provider capacity and to encourage innovation.

**3. Transforming the health care system requires provider and payer access to reliable, targeted, and efficiently produced data on the cost and quality of care. SIM states are grappling with how to build the required foundation for health information technology.**

Expanding a state's health information technology (HIT) infrastructure to encourage broader use of electronic health records, integrate clinical and administrative data, build all-payer claims databases, and hold providers accountable for quality requires “a completely new approach to data collection and use,” according to a SIM participant. Thoughtful HIT design depends on a shared vision across public and private payers to hold providers accountable for quality, to provide transparency to consumers and the public, and to help state leaders to target health system policies and resources. However, the most difficult task for SIM states may be building consensus on how they and their partners can create a system for collecting and analyzing data that supports patient-centered and value-based care.

Experienced staff members in SIM states and HIT advisors stress several key steps. The first is to set information goals for the SIM project: “a vision is needed before strategy development.” The second is to determine how to define progress, keeping in mind that improving HIT is “a long-term and disruptive process in the health system.” And the third is to focus on a few simple HIT improvements—an approach that “may be immensely powerful.”

SIM states are recognizing that a value-based delivery system and HIT development go hand in hand. To ensure that outcome, states are likely to seek guidance from CMS officials on how to use data to drive improvements in the health care system, and how to design HIT architecture to enable efficient and secure data collection and use.

**4. State governments have many—and often overlooked—policy levers to ensure an adequate supply and distribution of a well-trained and diverse health care workforce. However, the interests and culture of provider groups often divert attention from those levers.**

The U.S. health care workforce—including primary care and specialty physicians, licensed professionals such as nurses and physician assistants, and paraprofessionals such as community health and personal care workers—is growing rapidly. Still, an estimated 60 million Americans, or nearly one of five, lack adequate access to primary care because of a shortage of primary care physicians in their communities.<sup>4</sup> And researchers predict that the shortage will worsen in coming years.<sup>5</sup> Citing concerns over quality as well as the threat to their livelihoods, many physicians oppose expanding the scope of practice of nonphysician professionals, and this opposition has thwarted attempts to expand the primary care workforce in some states.

The SIM initiative gives states the opportunity to consider the supply and distribution of the current health care workforce, barriers to the effective use of health professionals, how to organize them into new roles and teams, and how to meet future workforce needs. States that focus on alternative and perhaps more cost-effective methods of delivering care could expand their supply of health care professionals while providing jobs and training to state residents.

State budget decisions—such as funding for programs at community colleges that train and certify community health workers—are key policy levers for shaping the health care workforce. Other policy levers include scholarships and loan repayment options for those who undergo such training; licensing and certification standards; regulations on the scope of practice of health care professionals; regional Workforce Investment Boards; and public-sector payments for health care through Medicaid and the state employee system.

Experts on the health workforce caution against focusing exclusively on scope of practice, and

overlooking the long-term nature of the educational pipeline and the uncertain short-term return on investment. Changing the supply of health professionals requires many years. States must work with medical associations and boards to assuage legitimate concerns and incorporate cost and quality into accreditation, certification, and curricula.

**5. States should forge early consensus on the scope and goals of their SIM projects, as their design will affect reform activities and outcomes.**

State SIM officials are enthusiastic about setting expansive goals for their projects but anxious about whether they are overly ambitious. As they seek to improve health care delivery, many are focusing on improving payment methods and developing accountable care organizations and medical homes. Yet some states are uncertain about whether or how to incorporate other critical areas into their SIM plan, such as public health interventions and long-term services and supports.

State officials working on SIM projects also express uncertainty about their expertise in choosing innovations and tying them together. They recognize

**How to integrate public health into the design of State Health Care Innovation Plans:**

- Engage state public health officers in building on existing projects, and form multistakeholder learning collaboratives to test, share, and implement evidence-based strategies for improving access to care.
- Conduct community assessments to identify health care disparities, gaps, “hot spots,” and drivers of poor health, such as physical inactivity and poor nutrition, and target interventions to local needs.
- Take stock of existing resources for delivering health care, and connect them through electronic health records, team-based care, and a 24-hour live telephone service (211) that connects residents to a wide variety of human services or social services across the state.

that the grant program simply does not provide enough time to tackle all the fundamental changes in health care delivery highlighted by partners and stakeholders. Yet early consensus on initial goals can help to focus efforts, build support, and establish a foundation for future, more expansive reforms.

## CONCLUSIONS AND POLICY RECOMMENDATIONS

States face formidable political and budgetary constraints as they design and test health care innovations and consider how to implement them on a large scale. Some states lack political support for a more regulated approach to health care financing, yet appear uncertain about which policy levers can promote market-based reforms. During earlier efforts to reform health care, states and stakeholders often overinvested time and resources in analyzing data and refining policy options, and underinvested in driving the political, legislative, and budget agenda.

To improve the chances that their SIM projects will succeed, states can heed the lessons and avoid the mistakes in states that have already begun transforming their health systems. For example, given time constraints and political impediments, SIM officials may be tempted to initiate a planning process that excludes key stakeholders (such as public health or consumer advocates) or ignores their concerns, resulting in lack of broad support for the plan. ***It is imperative for state SIM officials to listen to these stakeholders and communicate that they are being heard during the design and testing phases, to alleviate anxiety and address emerging concerns.***

At the same time, model-pretesting and model-design states must develop a plan in a relatively short period of time. This requires identifying a project team with a neutral facilitator, giving staff members specific responsibilities, and using check-ins, checklists, and deadlines to ensure that they fulfill them. Once states submit their plans and proposals for Design Testing awards to the Innovation Center, state officials must continue to plow ahead until the grant is awarded. ***States must also build in a realistic period for ramping up reform, as hiring staff and securing vendors***

***(e.g., for information technology or other technical or analytic assistance and expertise) takes time.***

***SIM staff would do well to articulate goals and outcomes for the state plan and then step aside, giving legislators and stakeholders the flexibility to encourage innovation in achieving the outcomes.*** Being too prescriptive can undermine the project's objectives.

***States could consider venues for reforms that can produce early wins, such as hospitals and physician groups that support reform efforts.*** Early wins will signal that changes in health care delivery and payment systems can work, and help build momentum for larger-scale innovations.

***For their part, when reviewing state plans, setting timetables, and providing support, federal officials need to understand the constraints that states confront.*** Time constraints, for example, can jeopardize states' ability to show a return on their significant investment of federal funds. The uncertain cost of sustaining a new model after SIM funding ends is also a barrier to reform.

In response to such concerns, CMS recently announced a no-cost option that allows model-design states to extend their six-month time frame by 60 days.<sup>6</sup> SIM staff at CMS should also respond to state feedback and encourage their Medicare colleagues to engage with state officials on multipayer initiatives.

Fortunately, CMS is already collaborating with other federal agencies—including the Centers for Disease Control and Prevention, the Health Resources and Services Administration, and the Office of the National Coordinator for Health Information Technology—on improving the health care delivery system. These agencies can provide significant expertise and resources. CMS must ensure that these federal officials support states in developing their State Health Care Innovation Plan by the end of 2013, and during early testing of the plan. CMS must also ensure that federal agencies coordinate their various programs and initiatives related to health care reform.

As SIM projects move forward, states will likely seek to take “deeper dives” into technical areas such as return on investment (to ensure the reforms

are cost-effective) and attribution,<sup>7</sup> measurement of outcomes, health care financing and reimbursement, legal considerations, and identification of a tolerable growth rate in health care costs. *To help states tackle these challenges, CMS and its partners must continue to provide technical assistance and venues to enable states to share experiences, lessons, and best practices.*

Technical assistance is available to states through a **SIM Resource Support Contractor**—a team led by NORC at the University of Chicago. Team members include the State Health Access Data Assistance Center, the Center for Health Care Strategies, the National Governors Association, Manatt Health Solutions, and Mercer Consulting. The team works with states to develop and implement their models, and assesses their readiness to do so.

## Exhibit 2. State Innovation Models: A Snapshot

| <b>Model-Testing States</b>    |  |
|--------------------------------|--|
| Arkansas (\$42 million)        | The Arkansas model focuses on two complementary strategies: developing patient-centered medical homes for those with chronic conditions, and episode-based payment launched statewide with the support of both public and private insurers.  |
| Maine (\$33 million)           | Maine will test its plan for improving health care quality and population health by supporting the formation of multipayer accountable care organizations (ACOs) that commit to providing greater value in return for performance-based payment for high-quality care.   |
| Massachusetts (\$44 million)   | Massachusetts's approach builds on previous health reform efforts. SIM funds will support primary care practices as they transform into patient-centered medical homes and adopt shared-savings/shared-risk payments with quality incentives. SIM funds also will support public and private payers in transitioning to the new model.   |
| Minnesota (\$45 million)       | Minnesota's Accountable Health Model will integrate care across a continuum for each person. The model will also test a comprehensive, statewide program to close gaps in health information, create a quality-improvement infrastructure, and address workforce capacity essential for team-based coordinated care.   |
| Oregon (\$45 million)          | The Oregon Coordinated Care Model will use the state's purchasing power to realign health care payments and incentives. The state is testing its model through Medicaid coordinated care organizations—risk-bearing, community-based entities governed by a partnership of stakeholders.   |
| Vermont (\$45 million)         | Vermont is adopting and testing three models: shared-savings ACOs that integrate payment and services across the delivery system; bundled payments that integrate payment and services across multiple independent providers; and pay-for-performance, which aims to improve quality, performance, and efficiency.   |
| <b>Model-Pretesting States</b> |  |
| Colorado (\$2 million)         | Colorado plans to use its Statewide Health Innovations Fostering Transformation (SHIFT) to integrate behavioral and medical health care. At the practice level, SHIFT will support the formation of integrated primary care within the state's Medicaid ACOs, with payment incentives based on readiness to accept risk and integration of behavioral and clinical care.   |
| New York (\$1 million)         | New York will further develop its Health Care Innovation Plan, which includes teams for treating first-episode psychosis; support for care transitions; community-based care management for older adults and persons with developmental disabilities; ACOs; and regional quality-improvement collaboratives. Improvements in health information technology will promote the use of electronic health records, expand provider access to data, create an all-payer database, and allow monitoring of each care model. |
| Washington (\$1 million)       | Washington's model will create virtual ACOs that integrate and coordinate primary care providers, specialists, and health care facilities. The model also will redesign care delivery and payment by shifting from fee-for-service to approaches that provide incentives for integrating care, improving quality, and providing higher value. The model will work through the state's quality collaboratives.  |
| <b>Model-Design States</b>     |  |
| California (\$2.7 million)     | California plans to use existing state and national initiatives (such as capitated payments, ACOs, bundled episode payments, a Coordinated Care Initiative for dual-eligible Medi-Cal and Medicare beneficiaries, and a Section 1115 Medi-Cal Bridge to Health Care Reform waiver) to inform its model design to meet the needs of a diverse and geographically dispersed population.  |
| Connecticut (\$2.9 million)    | Connecticut plans to design system improvements that promote integrated care, use its health insurance exchange to connect consumers to coverage, expand the primary care workforce, and increase collaboration among regulators, providers, and consumers. The model will advance alignment across multiple payers on contracting and payment strategies to promote value and performance.  |
| Delaware (\$2.5 million)       | Delaware proposes to build on its strong foundation of collaboration among local providers to design a model that promotes new payment and service delivery models across public and private payers. The state also aims to enhance health data collection and analysis to support coordinated care and outcomes-based payment; and integrate workforce planning, behavioral health, and public health initiatives.  |
| Hawaii (\$938,000)             | Hawaii proposes to develop an integrated care model. The state will examine standardized definitions and payments for patient-centered medical homes and care management services; find ways to reduce waste and eliminate variation in administrative procedures among plans; address differences among plans in how licensed providers are reimbursed; and identify methods for telehealth reimbursement.  |
| Idaho (\$3 million)            | Idaho will use a multistakeholder approach to identify opportunities to improve care management through patient-centered medical homes. Stakeholders will also identify mechanisms for linking local health care through partnerships among hospitals, primary care providers, and county health and social service agencies.  |
| Illinois (\$2.1 million)       | Illinois plans to build on reforms in health care delivery and payment systems already under way. These include changes under the state's Care Coordination Innovations Project and its CMS Medicare–Medicaid enrollees demonstration project, and innovations spearheaded by private insurers. Planning activities include developing and integrating three models: a provider-driven model, a plan–provider partnership model, and a plan–provider–payer model.  |



|                               |  |
|-------------------------------|--|
| Iowa (\$1.4 million)          | Iowa plans to design ways to integrate care, develop strategies for aligning payments among key payers, and establish incentives for value-based purchasing and unified quality outcomes. The state also plans to integrate long-term care and behavioral health into its multipayer ACO approach, and to hold annual growth in total health care costs to less than 2 percent.  |
| Maryland (\$2.4 million)      | Maryland is designing a statewide multipayer Community Integrated Medical Home program, which will integrate community resources and local health entities to monitor and improve population health. The state is also modernizing its all-payer hospital waiver to include outpatient services and new performance metrics.   |
| Michigan (\$1.7 million)      | Michigan is focusing on four areas: patient- and family-centered health homes; coordination and accountability in “medical neighborhoods”; care bridges to behavioral health and long-term care; and integration of health care and community resources, such as through the Pathways Community Hub model. The state will identify policy levers and infrastructure requirements to prepare for the model’s rollout and monitoring.  |
| New Hampshire (\$1.6 million) | New Hampshire is developing a framework for aligning consumer access across delivery system silos, payer support for outcomes-based long-term care services, and global accountability for cost-effectiveness and outcomes. The state will identify opportunities for coordinating care for individuals who either need or are at risk of needing long-term services.  |
| Ohio (\$3 million)            | Ohio plans to pursue statewide implementation of new payment and delivery models. The goal is to create a roadmap for making qualified medical homes available to most Ohioans, and for defining and administering episode-based payments for acute medical events across Medicaid/CHIP, Medicare, and commercially insured patients.  |
| Pennsylvania (\$1.6 million)  | Pennsylvania aims to develop a model that deploys community-based care teams to provide services to “super-utilizers,” and enhances access to preventive services by integrating them with the provider community. The model also will spur alignment of patient, provider, and payer interests through gain-sharing models. The project includes designing an infrastructure to support the model.  |
| Rhode Island (\$1.6 million)  | Rhode Island seeks to develop a model that builds on its patient-centered medical home initiative and focuses on community-centered care. Planning will include a multistakeholder process to review existing reforms in payment and delivery systems; identify data sources and baseline data for outcomes measures and financial analysis; and develop policies to implement the state’s plan.   |
| Tennessee (\$756,000)         | Tennessee proposes to develop and integrate specific and scalable purchasing strategies into its TennCare Medicaid managed-care model. The state also aims to accelerate efforts to hold health care providers accountable for cost and quality of care by identifying and rewarding the best-performing providers based on federally recognized quality metrics.  |
| Texas (\$2.9 million)         | Texas seeks to develop a consensus among payers, providers, and other stakeholders on the design of innovative models and the elements needed to implement them. Challenges to be addressed include gaps in health information technology; sources of clinical and financial data and requirements for them; and performance measures needed to design alternative payment systems that incorporate quality-based outcomes.  |
| Utah (\$942,000)              | Utah will design a statewide approach to better physician–patient communication and care coordination, with the goal of improving health care quality and lowering costs. The state will convene a multistakeholder group to address strategies for health care transformation in five areas: expanded health information technology, the health care workforce, promotion of wellness and healthy lifestyles, payment reform, and medical malpractice and dispute resolution. |

Source: Centers for Medicare and Medicaid Services. See <http://innovation.cms.gov/initiatives/state-innovations-model-testing/>.

## NOTES

- <sup>1</sup> The National Governors Association convened the meetings for state and federal officials in Baltimore, May 14–15, 2013. Parts of this brief were drawn from the presentations of those officials, as well as from other experts' presentations. The meetings were supported by a grant from The Commonwealth Fund.
- <sup>2</sup> Because Medicaid payments to providers are often far lower than payments from Medicare and commercial payers, some Medicaid officials are uncertain about how to partner with payers to produce savings.
- <sup>3</sup> B. Wirth and M. Takach, *State Strategies to Avoid Antitrust Concerns in Multipayer Medical Home Initiatives* (New York: The Commonwealth Fund, July 2013).
- <sup>4</sup> *Primary Care Shortage*, Background Brief, KaiserEDU.org, <http://www.kaiseredu.org/Issue-Modules/Primary-Care-Shortage/Background-Brief.aspx>.
- <sup>5</sup> “Study Predicts Shortage of Primary Care Doctors Will Worsen,” *Kaiser Health News*, Nov. 21, 2012, <http://www.kaiserhealthnews.org/daily-reports/2012/november/21/doctor-shortage.aspx>.
- <sup>6</sup> This would extend the period for conducting the analysis, collaboration, and design work to November 30, and the deadline for submitting a State Health Care Innovation Plan to CMS to December 31, 2013.
- <sup>7</sup> Attribution refers to the method of defining or assigning patient populations to ACOs. For example, a prospective method uses data from one year to assign patients to an ACO for the following performance year. A retrospective or performance year method assigns patients to an ACO at the end of the performance year, based on the population served during the performance year.

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