RURAL HEALTH SYSTEM CHANGE EMBEDDED IN STATE INNOVATION MODELS

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WHAT IS A SIM?

- The State Innovation Models (SIM) Initiative, administered by the Center for Medicare and Medicaid Innovation (CMMI) provides states with financial and technical support to develop and test multi-payer health care payment and service delivery models
- Six states were in the first round, now in second year of model testing
- Additional 11 states are in round two, in the first year of model testing

WILL INNOVATION MATTER IN RURAL LOCATIONS?

- Resources are significant: $250 million in round one model test awards, $622 million in round two
- States include rural sites in statewide efforts
- Engagement of rural providers and other stakeholders will influence total impact

THE RURAL HEALTH VALUE PROJECT

- Summarize SIM plans in the round one states
- Present information about activities in round one states
- Continue to monitor developments
- Incorporate round two states?
- First project document is in draft form, expect release in early December

ROUND ONE STATES

- Arkansas
- Maine
- Massachusetts
- Minnesota
- Oregon
- Vermont

A WORD ABOUT METHODOLOGY …

- Abstract information available from CMMI
- Detailed information available from state website, at least about their plans
- Additional information from contacting states directly
- Annual reports to CMMI (posted to the innovation.cms.gov web site)

THE RURAL IMPACT OF SIMS: RURAL COMMITMENTS

- **Arkansas**: increasing technical capacity and number of providers in medically underserved rural communities
- **Colorado**: primary care practice transformation in 400 sites includes 21 rural sites in the first of three cohorts; using extension model to connect medical practices with local resources such as public health
- **Idaho**: state-wide transformation of system through use of PCMHs, including virtual PCMH model in remote areas

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THE RURAL IMPACT OF SIMS: RURAL COMMITMENTS

- **Oregon**: emphasis on expanding capacity and improving service and sustainability in rural and frontier regions
- **Minnesota**: Accountable Communities for Health in rural are using e-health grants and e-health roadmaps; capacity building using emerging professions including community health workers, community health workers, and dental therapists
- **Vermont**: Some 61% of population resides in federally defined rural regions, statewide structural reforms will affect them

EMERGING THEMES

- Improving the capacity of the delivery system in rural places
- Implementing financial risk-sharing in payment systems
- Using primary care medical homes (PCMHs) and integrated care more generally
- Programmatic initiatives in coordinated care

INCREASING SYSTEM CAPACITY

- **Arkansas**: Programming to increase recruitment and retention; promoting adoption of new information technology
- **Minnesota**: Emerging Professions Integration Program
- **Vermont**: funding improved clinical and claims data transmission, integration, analytics, and modeling; improved capacity to measure and address health care workforce needs

FINANCIAL RISK SHARING

- **Arkansas**: Retrospective payment for episodes – 13 implemented, gain sharing payments up to $3,000 and risk sharing up to $7,200 for 654 episodes in 2014
- **Oregon**: Using 16 Coordinated Care Organizations to implement alternative payment methodologies, goal is pay for performance
- **Vermont**: Including commercial payers and Medicaid in shared savings ACO model, including pay-for-performance models

INTEGRATED CARE: USE OF PCMHS

- **Arkansas**: Focus on Medicaid enrollees, 243,000 Medicaid clients (70% of state total) included as of 2014, 30% above expected levels for the first wave
- **Colorado**: Integrated health homes, including in four Community Mental Health Centers

USE OF PCMHS: IDAHO SYSTEM TRANSFORMATION

- **Goal 1:** Accelerate establishment of PCMH model by building 180 PCMHs with at least level-1 recognition or accreditation: $30,000 in start-up incentives to 60 practices
- **Goal 2:** Improve care coordination by improving real-time communication between providers, patients , and other entities through use of EHRs and HIE connections among 180 PCMHs
- **Goal 3:** Support integration of each PCMH with local Medical Neighborhood

USE OF PCMHS: IDAHO SYSTEM TRANSFORMATION

- **Goal 4:** Improve patient access to PCMH-based care in geographically remote areas by supporting Virtual PCMH Model – incentive payments to providers for $5,000 including training EMS and Community Workers to help with shortage disparities
- **Goal 5:** Build statewide system for collecting, analyzing and reporting quality and outcome data
- **Goal 6:** Test transformation from FFS system to one that incentivizes value; phased payment model
- **Goal 7:** Determine cost savings and return on investment of the model

INTEGRATED CARE: COLORADO MODEL

- Program goal to transform primary care practices to integrated physical and behavioral healthcare services, with value-based payment structures for 80% of residents by 2019
- Programs based on 10 practice milestones from Colorado Framework for Whole Person Care
- Goal: Primary Care Practices across the state in 3 cohorts, first one in February, 2016 of 100 practices

INITIATIVES IN COORDINATED CARE

- Oregon - Cycles of activity:
  - Innovation and Rapid Learning: resource to CCOs, rapid innovation cycles, health equity across all aspects of continuum of care
  - Delivery: management of primary, specialty, behavioral, and oral care; preventive services; long-term care, social support
  - Payment: volume-to-value based payments and budgets
- Vermont: Care model or models for dually-eligible residents that improves beneficiary service and outcomes

COORDINATED CARE: MINNESOTA 2017 GOALS

- Majority of patients receive care that is patient-entered and coordinated across settings
- Majority of providers participate in ACO or similar models that hold them accountable to the triple aim
- Communities, providers, and payers have begun to implement new collaborative approaches to setting and achieving population health improvement goals

MINNESOTA ACCOUNTABLE COMMUNITIES FOR HEALTH GOALS

- Select, support and evaluate up to 15 ACHs
- Encourage clinical and community partnerships that provide patient-centered coordinated care for the whole person
- Determine whether ACHs in partnership with ACOs result in improvements to quality, cost and experience of care

MINNESOTA MODEL FEATURES

- Flexible risk models for large integrated systems, small or independent providers, and other partner organizations to ensure broadest possible participation
- Work within existing fee-for-service and managed care structures to allow faster implementation timelines and least disruption
- Aligns with payment models in commercial market and other emerging national models (Next Generation ACOs, Shared Savings)

MINNESOTA 2015 PROGRAM UPDATE

- 205,000 receiving care through ACOs (exceeds 2015 goal)
- $61.5 million IHP cost savings (2016 goals is $100 million)
- Achieved goal of 15 ACH by 2015
- 41% of fully insured Minnesotans covered by an ACO or Total Cost of Care Model (2016 goal is 60%)

CONCLUSION

- Should continue to track progress of both Round One and Round Two awardees
- Rural people and providers are part of the implementation of SIMs
- Future is at the moment uncertain

FOR FURTHER INFORMATION

The RUPRI Center for Rural Health Policy Analysis
http://cph.uiowa.edu/rupri

The RUPRI Health Panel
http://www.rupri.org

Rural Telehealth Research Center
http://ruraltelehealth.org/

The Rural Health Value Program
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