RURAL HEALTH SYSTEM CHANGE EMBEDDED IN STATE INNOVATION MODELS

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

Rural Telehealth Research Center
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