

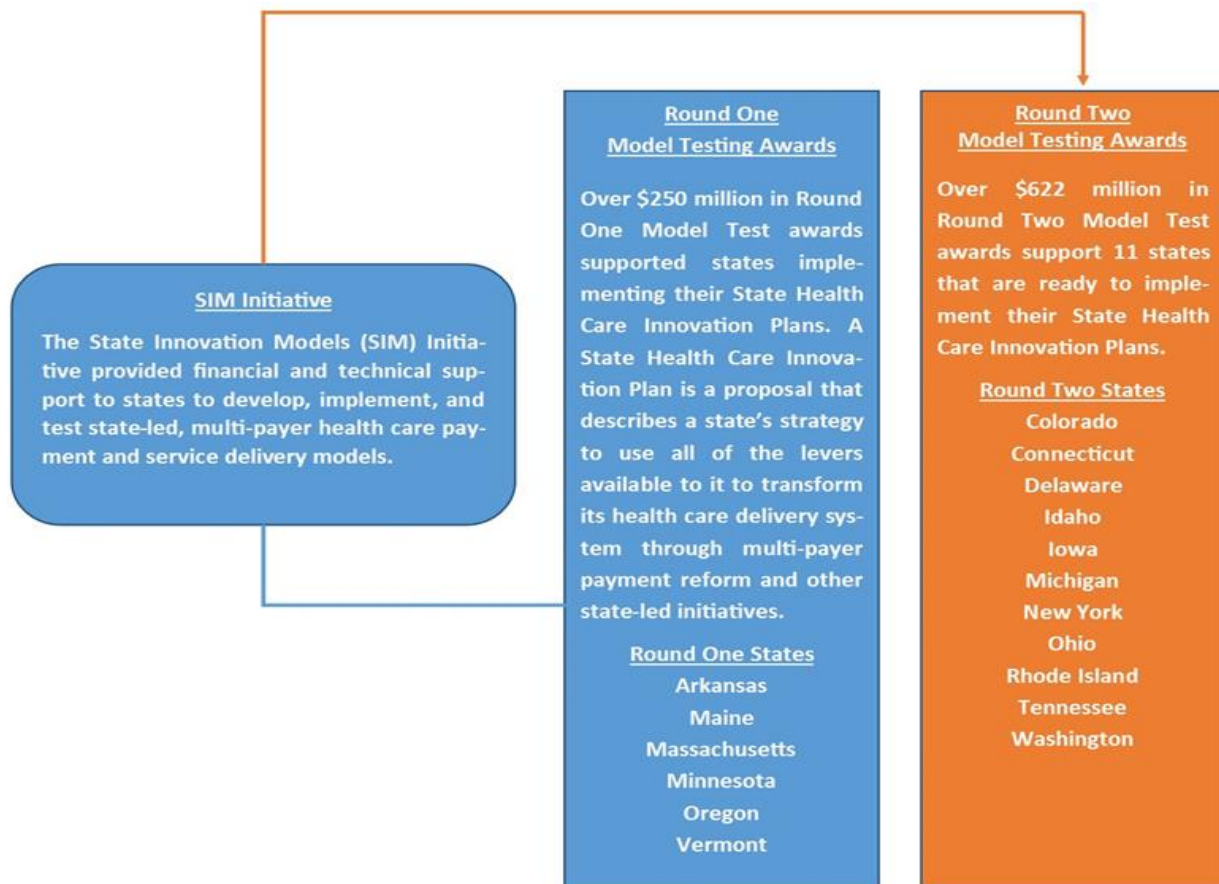
**State Innovation Model Testing Awards  
From the Center for Medicare & Medicaid Innovation:  
Highlighting Rural Focus  
July 2017**

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## INTRODUCTION

The Centers for Medicare & Medicaid Services' Innovation Center established the State Innovation Models (SIM) initiative in 2012 to support states that are committed to designing and “pre-testing” strategies for health system transformation, or testing delivery and payment models newly implemented in their states. The aim of the SIM initiative was to test and promote multi-payer models for providing patient-centered care, improving care quality, and slowing the projected growth of costs in Medicare, Medicaid, and the Children’s Health Insurance Program (CHIP).<sup>i</sup> SIM efforts rested on the unique capacities and authorities of the states under special Medicaid waivers, and their ability to coalesce key stakeholders into the innovation effort.<sup>ii</sup> In round one of the initiative that began in 2013, the Innovation Center awarded over \$250 million in model test awards to six states to assess state-level models for multi-payer payment and delivery system transformation as proposed in the states’ previously designed State Health Care Innovation Plan. In round two beginning in 2014, an additional 11 states received \$620 million for that same purpose.<sup>iii</sup> This paper summarizes activities and early accomplishments of six states, [Arkansas](#), [Colorado](#), [Idaho](#), [Oregon](#), [Minnesota](#), and [Vermont](#), whose SIM plans included testing efforts specifically targeting rural areas. The innovation plans in round one specifically include multi-payer delivery and payment models, efforts to improve the quality of services including health IT, evidence based investments, workforce capacity expansion, enabling policy mechanisms, and effective evaluation.<sup>iv</sup>

Figure 1 – SIM Model Testing Awards



## **ARKANSAS (ROUND 1, \$42 MILLION)**

FEBRUARY 2013 – AUGUST 2016

**Goals:** Ensure access to services and increase technical capacity and the number of providers in medically underserved rural communities.

Arkansas received its SIM grant in February 2013, and used the funds to implement its State Improvement Plan over 42 months.<sup>v</sup> The Arkansas model emphasized patient-centered medical homes (PCMHs) as the hub of comprehensive care, value-based payments that included performance-based coordinated care fees, and graduated payments that reflected the assessed needs of the patient along with cost-control mechanisms that still ensure quality care for consumers.<sup>vi</sup> The Arkansas model was a statewide, comprehensive approach to meet the needs of its population, which is predominantly rural. The plan incorporated longstanding state-level goals for rural health, including ensuring access to services and increasing technical capacity and the number of providers in medically underserved rural communities. These goals incorporated streamlined episode-based payment innovations that rewarded the achievement of target outcomes, particularly quality and cost-level benchmarks, with the goal of sustainability for rural providers. Additionally, the State committed to workforce development in the form of increased recruitment and retention of quality providers to rural regions and promoting technical capacity building among rural providers to promote the adoption of team-based models. For providers that were too small to qualify as PCMHs, Arkansas allowed practices to pool voluntarily to meet the minimum patient panel sized of Medicaid beneficiaries.<sup>vii</sup> Arkansas also promoted the adoption of new health information technology (HIT) and improvements to the State's HIT infrastructure to further increase the quality and cost-effectiveness of rural care.<sup>viii,ix,x,xi</sup>

### **Patient-Centered medical Homes (PCMH)**

- Designed to improve quality and contain costs by supporting the delivery of better-coordinated, team-based care.
- Multi-payer approach that has found broad support from the State and providers.
- Enrollment has surpassed expectations; as of October 2015, Arkansas' SIM plan covered 331,000 Medicaid clients (82% of the total eligible Medicaid beneficiaries, over 50% of all beneficiaries) in PCMHs.<sup>xii</sup>
- There were 135 of 263 eligible practices serving as PCMHs statewide (including 780 primary care providers (PCPs), estimated at 70% of eligible Medicaid PCPs and 36% of all active PCPs in the State), with an additional 63 practices engaged in the Comprehensive Primary Care initiative.<sup>xiii,xiv</sup>
- In 2014, Medicaid realized \$34.3 million in direct cost-avoidance through trend reduction, of which \$12.1 million went toward care coordination payments to providers, and \$22.2 million was shared between the State and qualifying providers, with several clinics receiving over \$100,000.<sup>xv</sup>

### **Retrospective Episode-of-Care (EOC) Base Payment**

- Medicaid provided incentivized payments for coordinated, team-based care for specific conditions and procedures, under the leadership of a designated principal accountable provider (PAP).
- Medicaid participated in all episodes of care; commercial payers participated only in those episodes with the greatest impact on their enrollee populations.
- Payments reflecting the assessed level of need for each clients enhanced services for special needs populations.

- The State also developed prospective, assessment-based and institutional services for people with developmental disabilities and physical disabilities requiring long-term services and supports.
- As of first quarter 2015, 14 retrospective episodes of care (EOC) implemented with an additional 10 in development, though the initial benchmark of 50 episodes was determined to be an unrealistic goal for the first 2-3 years of the initiative.
- 2,200 (41%) active patient care physicians have received EOC payments.
- Payers included Medicaid, Blue Cross Blue Shield, and QualChoice.
- 637 primary care physicians were also engaged in gain-sharing, representing 179 practices.<sup>xvi</sup>

#### **Population-Based Care Delivery**

- The SIM plan aimed to provide a majority of Arkansas residents with access to PCMHs to provide team-based, comprehensive care with a focus on chronic care management and preventive services.
- PCMHs specifically aimed to reduce ambulatory ER visits, inpatient admissions, and readmissions.
- Capitated fees and shared saving held physicians responsible for their entire Medicaid population.
- Payments included performance-based care coordination fees and shared-value/quality-based fees.

#### **Health Homes**

- Individuals with complex/special health needs were provided access to health homes that coordinated with their medical homes to provide medical and wraparound services, with 24/7 access.
- The State implemented an incentivized payment structure based on outcomes, evidence-based practices, and wellness promotion.
- Capitated fees were included to pay for care coordination.<sup>xvii</sup>

#### **Arkansas Rural Provider List (PCMHs and Health Homes):**

- SAMA Healthcare Facilities
- Southwest Arkansas Counseling & Mental Health Center, Inc.
- Behavioral Management Systems, Inc.
- Preferred Family Healthcare
- Jerry Blaylock, MD
- Northeast Arkansas Community Health Center
- Western Arkansas Counseling and Guidance Center
- Quapaw House, Inc.
- 10th District Substance Abuse Program.
- Community Counseling Services, Inc.
- Counseling Associates, Inc.
- Counseling Clinic, Inc.
- Delta Counseling Assoc.
- Health Resources of Arkansas
- Ozark Guidance Center
- South Arkansas Regional Health Center
- Southeast Arkansas Behavioral Healthcare System, Inc.
- Birch Tree Communities

## **COLORADO (ROUND 2, \$65 MILLION)**

FEBRUARY 2015 – JANUARY 2019

**Goal:** Transform primary care practices by integrating physical and behavioral health care services in coordinated systems, with value-based payment structures for 80 percent of residents by 2019.

The Colorado model, called the Colorado Framework, focuses on integrated physical and behavioral health as a means to achieve the health care triple aim of increased access to care, improved health outcomes through quality, and reduced costs. To accomplish the integrated care model, Colorado uses SIM funds to improve the State's health care infrastructure. The State seeks to implement coordinated community systems, with a value-based payment model, for 80 percent of the State's residents by 2019. The Colorado Framework rests on key stakeholder relationships, including eight leading commercial payers, and primary care providers covering the vast majority of the State's population. The Framework aims to integrate physical and behavioral health care in more than 400 primary care practices and community mental health centers (CMHCs) with about 1,600 primary care providers. It seeks to bring the majority of payers into shared risk and savings programs by 2019. Additionally, it works to expand information technology efforts, including telehealth, launch a robust evaluation program that measures both processes and outcomes, and implement a statewide plan to improve population health.<sup>xviii xix xx xxi</sup>

### **Primary Care Practice Transformation**

- Providers receive transformation support packages for opting into alternative payment models, through the State's Foundation Building Opportunities to build competencies, business processes, and increase the use of HIT.<sup>xxii</sup>
- Providers reflect the 10 practice milestones from the Colorado Framework for Whole Person Care, and report their progress through a provided Clinical Health Information Technology Advisor.
- Major health plans in the state agreed to provide participating providers with enhanced, value-based payments, and must align with the Health Care Payment and Learning Action Network Alternative Payment Model Framework.
- Practices are eligible for up to \$5,000 in participation payments, and compete for small grants totaling \$6 million through the SIM Practice Transformation Fund and the Colorado Health Foundation.

**Goal:** 400 Primary Care Practices across the State of Colorado in three cohorts - The first cohort of 100 practices launched in February 2016.

### **Participating Rural Providers – Cohort 1:**

- Castle Valley Children's Clinic
- Community Health Clinic
- David M. Arnett MD PC (DBA Saluda Family Medicine)
- Doctors Plus of Colorado, Inc.
- High Plains Community Health Center, Inc.
- Mercy Family Medicine – Mercado (Horse Gulch)
- Mid-valley Family Practice
- Pediatric Associates Prof. LLC
- Pediatric Partners of Glenwood
- Pediatric Partners of the Southwest

- Rangley Family Medicine
- Roaring Fork Family Practice
- Roaring Fork School Health Centers
- Rocky Ford Family Health Center, LLC
- Saluda Family Health Centers – Fort Morgan
- Saluda Family Health Centers – Sterling
- Sterling Primary Care
- Telluride Medical Center
- Town Clinic of Crested Butte
- Rural Practice Transformation Organizations
- Colorado Rural Health Center

### **Bi-Directional Integration Pilot**

- The pilot program created integrated health homes in four CMHCs across the State.
- CMHCs provide comprehensive behavioral and physical health care to stabilize and manage illness and support recovery.
- The Southeast Health Group in La Junta is a rural bi-directional integrated health home site.
- Participating Providers:
  - Community Reach Center, based in Commerce City
  - Jefferson Center for Mental Health, based in Lakewood
  - Mental Health Partners, based in Boulder
  - Southeast Health Group, based in La Junta
    - This CMHC operates in rural and frontier areas of the State.

### **Extension Services**

- The Extension Services program connects medical practices with local resources, particularly public health agencies, across the State. The primary goal of this program is to ensure patients receive comprehensive, wraparound services.
- The Colorado Health Institute is under contract to the State SIM office to lead program development, providing governance, coordination, and oversight.
- Regional health connectors who link providers and local health organizations staff the Extension Services program. Local organizations host regional health connectors who operate services and train local staff to provide services.
- Partner organizations include the Colorado Health Extension System and the University Of Colorado School Of Medicine.

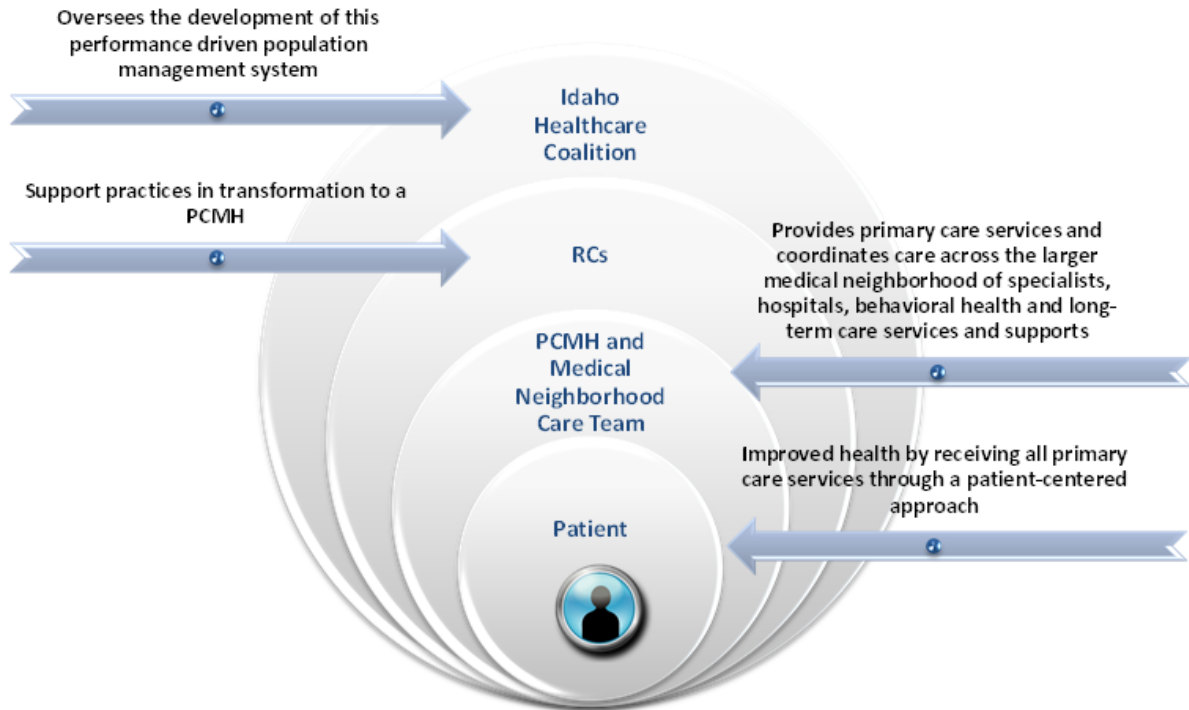
**IDAHO (ROUND 2, \$40 MILLION)**  
FEBRUARY 2015 – JANUARY 2019

**Goal:** To achieve statewide transformation of the health care system through the PCMH model, to provide integrated primary care.<sup>xxiii</sup>

To facilitate this transformation, Idaho will build 180 nationally recognized PCMH practices, including 75 virtual PCMHs, by the end of the model test.<sup>xxiv</sup> Idaho identified seven program goals that serve as benchmarks for model evaluation.<sup>xxv</sup>

1. Accelerate establishment of the PCMH model of care throughout the State by building 180 PCMH practices (defined as a clinic site) that have reached at least level-1 PCMH recognition or accreditation within their first year of participation in the model test. The State is using outreach and education, along with financial incentives, to accomplish this goal. For each of three years, the State is distributing \$30,000 in start-up incentives to 60 PCMH-designated practices for a total of \$1,800,000 per year.
2. Improve care coordination by improving real-time communication between PCMHs, their patients, and other entities across the health care system through adoption and use of electronic health records (EHRs) and health information exchange (HIE) connections among the 180 PCMHs, and by building statewide capacity for data exchange across the system.
3. Support the integration of each PCMH with the local medical neighborhood by establishing seven regional collaboratives.
4. Improve patient access to PCMH-based care in geographically remote areas of Idaho by supporting a virtual PCMH model through provider incentives and providing training to community health workers, and by integrating telehealth into health information technology plans for these areas. The program uses incentive payments to providers of \$5,000, for up to 75 participating PCMHs, to increase telehealth utilization, and trains EMS and community health workers to help with shortage disparities.
5. Build a statewide system for collecting, analyzing, and reporting quality and outcome data at the PCMH, regional, and State levels. This system will provide critical feedback at the practice, regional, and State levels.
6. Test transformation to a fee-for-service system that incentivizes value, rather than volume, by aligning value-based payment mechanisms across payers.
7. Determine the cost savings and return on investment of the model, and progress toward meeting implementation goals throughout the model test period, as well as health outcomes predicted by the model.<sup>xxvi</sup>

**Figure 2 – Idaho Patient-Centered Model of Care**



*Idaho Department of Health & Welfare  
State Healthcare Innovation Plan. Available at: <http://ship.idaho.gov/>*



## **OREGON (ROUND 1, \$45 MILLION)**

### SEPTEMBER 2013 – SEPTEMBER 2016

**Goals:** Oregon’s SIM plan focused on testing and expanding its coordinated care model, to more effectively and efficiently address the health needs of the State’s population, and to achieve program aims through restructuring of the State’s care model and the health system’s business model.

The State’s Transformation Center tested and evaluated the various elements of the coordinated care model. As testing and evaluation occurred, the State shared the most effective delivery system elements and payment modifications with the multiple payers in the system. Oregon’s plan emphasized expanding capacity and improving service and sustainability in the State’s rural and frontier regions. Integrated care and streamlined payment, particularly through the transformation of local clinics into patient-centered primary care homes, helped address disparities affecting the health of rural communities and populations. Specific approaches to addressing the needs of rural communities in Oregon included regional health equity coalitions, leadership training, and capacity building through the DELTA project and the health interpreter projects, and through community prevention grants that sought to streamline and build capacity based on previously observed community-level successes.<sup>xxvii, xxviii</sup>

Oregon has a unique Medicaid population as almost the entire population enrolled in managed care plans. Beneficiaries have extensive coverage for in-home long-term care services and for services needed outside the normal realm of care. In September 2012, the Centers for Medicare & Medicaid Services confirmed a SIM grant for a total of \$45 million for four years.<sup>xxix</sup> Oregon adopted a coordinated care organization (CCO) model in 16 communities in August 2012, which it continued developing with the SIM grant.<sup>xxx</sup> This SIM grant developed in three parts:

#### **Innovation and Rapid Learning**

- Resource support to the designated CCOs
- Rapid Plan-Do-Study-Act (PDSA) innovation cycles
- Health equity across all aspects of the continuum of care

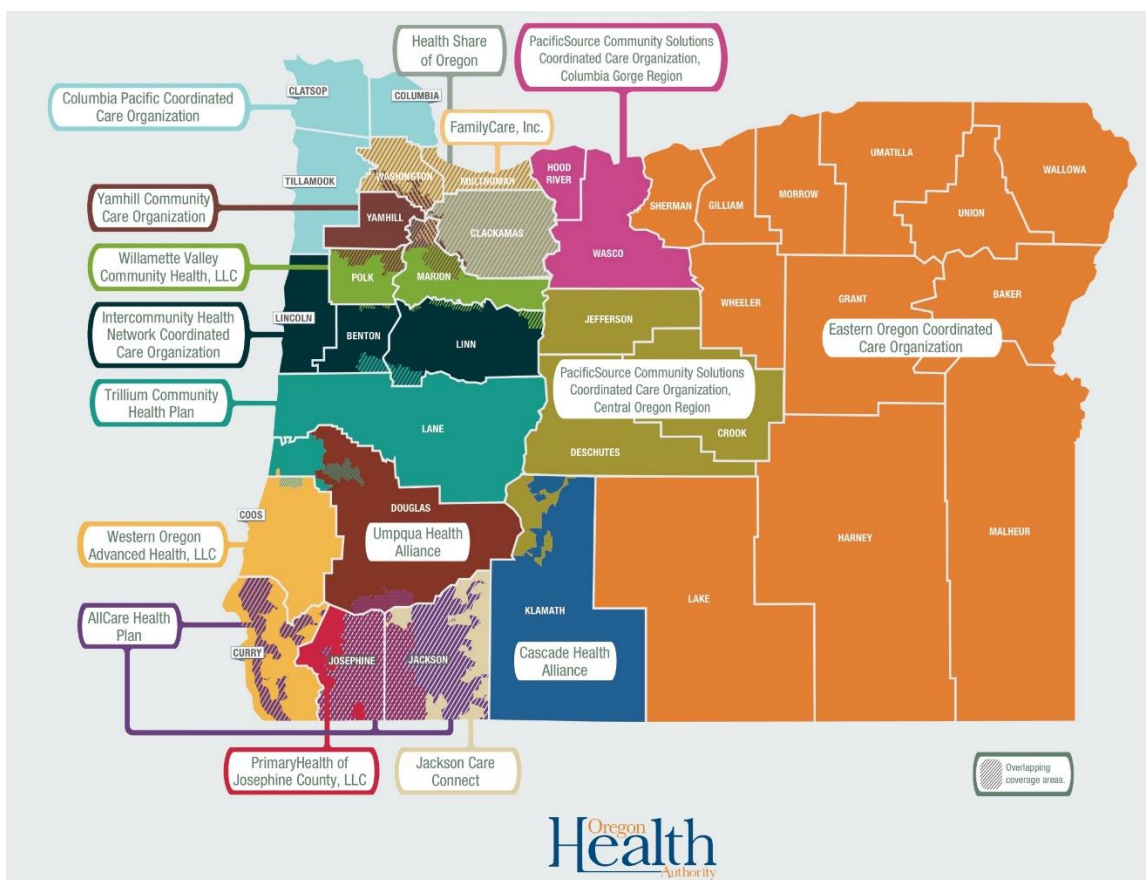
#### **Delivery**

- Management of primary, specialty, behavioral, and oral care
- Preventive services in the community
- Long-term care, social support, and community health with various organizations

#### **Payment - volume-to-value-based payments and budgets**

Oregon developed around 660 patient-centered primary care homes, distributed among the 16 CCO community networks mentioned previously.<sup>xxxi</sup> Figure 3 depicts the geographic service areas of the 16 CCOs along with brief descriptions of each.<sup>xxxii</sup> As of May 2017, there is not a comprehensive list of providers participating in the CCO networks.<sup>xxxiii</sup> However, detailed information on each CCO, including official organization webpages that link to participating providers is available through CCO Oregon.<sup>xxxiv</sup> Each CCO was required to use a community advisory committee. There were no required membership criteria, but the Oregon Health Authority suggested membership characteristics including being individuals or caretakers of those served by the CCO and the Oregon Health Plan, be community members or stakeholders, or serve on the board of the CCO.<sup>xxxv</sup> The CCOs were community owned and contracted with providers in shared-risk agreements. The 16 CCO networks met monthly to share best practices on an annual quality improvement topic.

**Figure 3 – Oregon Coordinated Care Organization Service Areas**



Transformation Center Oregon CCOs. *Oregon.gov*. N.p., 2015. Web. 23 Apr. 2016.

Innovations tracked by the Oregon Health Authority utilized 17 different metrics, published twice per year.<sup>xxxvi</sup> The tracking helped to maintain quality and financial goals for population management. These goals focused on Oregon’s adaptation of the healthcare Triple Aim:

1. Improve the lifelong health of all Oregonians
2. Increase the quality, reliability, and availability of care for all Oregonians
3. Lower or contain the cost of care so it is affordable for everyone

Complementing the triple aim were five *levers* developed by a team to encompass the CCO model and its goals for improving the population health with multiple payers.<sup>xxxvii</sup>

**Lever 1:** Improve care coordination at all points in the system, especially for those with multiple or complex conditions, with an emphasis on primary care through patient-centered primary care homes.

**Lever 2:** Implement alternative payment methodologies to focus on value and pay for improved outcomes.

**Lever 3:** Integrate physical, behavioral, and oral health care with community health improvement.

**Lever 4:** Implement standards and accountability for safe, accessible, and effective care.

**Lever 5:** Test, accelerate, and spread effective delivery system and payment innovations, both for the Medicaid population and for other payers and populations through a State-coordinated Transformation Center.

CCOs received a per-member-per-month payment for their enrollees, with additional bonus and compensation packages for meeting and exceeding metric requirements. Four payment transformations helped to reduce costs and improve quality and patient satisfaction.<sup>xxvii</sup>

1. Providence Health Systems and Health Plan. Issued to public employees in a CCO and based on episodic care reimbursement for diagnosis, procedures, and comorbidities.
2. ACA Section 2703 state plan for reimbursement for high-risk patients in primary care. The State implemented this transformation with payers such as the Oregon Health Plan/Medicaid, Medicare, and the Comprehensive Primary Care Initiative (private sector).
3. Streamlined DRG coding for hospital and ambulatory services, including no reimbursement for hospital-acquired infections.
4. CCO payment based on outcomes instead of full capitation.

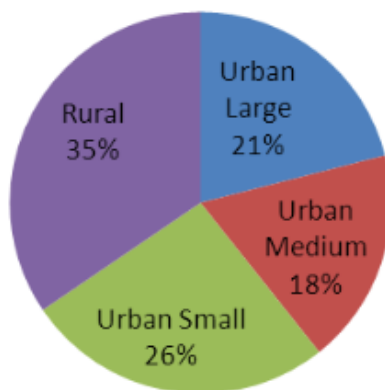
Oregon expected to save a total of \$372 million over the three-year SIM demonstration implementation period from these efforts and set the pace for future savings in the State.<sup>xxviii</sup> Payers and the exchange market implemented this future savings model through the creation of a central Transformation Center to encourage learning and information sharing.

As of first quarter 2015, the 16 CCOs operating within the State enrolled 911,680 (86%) Medicaid beneficiaries in coordinated care model, and 742,065 (70%) in patient-centered primary care homes.<sup>xxix</sup>

The State categorized geographic areas based on population size; the percentages of these categories shown in the Figure 4 include:<sup>xi</sup>

- Urban Large- greater than 200,000 people
- Urban Medium-100,000 to 200,000 people
- Urban Small- 40,000 to 100,000 people
- Rural- communities 10 miles or more away from an area with at least 40,000 people
- Frontier- counties with 6 people or fewer per square mile

**Figure 4 – Population Size of Oregon’s Patient Centered Primary Care Homes by Geographic Category**



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Source: Report on the Results of the 2012-2013 Supplemental Surveys, August 2013. Sherril B. Gelmon, DrPH and Rachel Trotta, MPH, Portland State University

*Oregon’s State Innovation Model Project Progress Report.* (2013) (1st Ed.). Available at: <http://www.oregon.gov/oha/OHPR/SIM/docs/SIMpercent20Progresspercent20Reportpercent20Oct-Decpercent202013.pdf>

## MINNESOTA (ROUND 1, \$45 MILLION)

FEBRUARY 2013 – DECEMBER 2017

**Goals:** Minnesota has identified the following goals for the SIM award, benchmarked for the end of 2017:

1. The majority of patients receive care that is patient-centered and coordinated across settings.
2. The majority of providers participate in an accountable care organization (ACO) or a similar model that holds them accountable for costs and quality of care.
3. The alignment of financial incentives for providers across payers, promotes increased access, improved quality, and reduced costs.
4. Communities, providers, and payers have begun to implement new collaborative approaches to setting and achieving clinical and population-level health improvement goals.<sup>xlii</sup>

The Minnesota approach rested on the Accountable Health model, which emphasized integrated team-based health care and payment models. The model built on the State's Integrated Health Partnership (IHP) demonstration, which adopted ACO, contracts to coordinate and integrate delivery to improve community health outcomes and quality of care, control costs, and streamline payment. Increasing access, improving quality, and overall practice transformation were the key agenda items for addressing the rural health needs in Minnesota. The State established 15 Accountable Communities for Health (ACH), which respond to the needs of challenged communities and coordinating services, including local public health, behavioral health, social services, and primary and long-term care providers, to improve overall community-level health. While not exclusively at work in rural communities and populations, the ACH model was the lynchpin of the SIM approach to addressing rural health needs in the State. Additionally, e-health grants and the e-health roadmaps to advance Minnesota ACH were major elements of the SIM strategy for rural health needs. Capacity building for rural communities in Minnesota included professional development focused on emerging professions for the State's health care workforce, specifically community health workers, community paramedics, and dental therapists. Incorporating and expanding these three professions was a key element of the practice transformation element of the model, and key to increasing access and quality of care for rural communities and populations at risk.<sup>xlii, xliii, xliv, xlv</sup>

Minnesota increased the kinds of care offered through ACOs, including for the first time long-term social services and behavioral health services. Doing so created linkages between ACOs and Medicare, Medicaid, and commercial insurers, aligning payments to provide better care coordination, wider access to services, and improved coverage. Minnesota also planned to work with community organizations to create ACH that integrated medical care with behavioral health services, public health, long-term care, social services, and other forms of care; shared accountability for population health; and provided care centered on the needs of individuals and families.

### **ACH Goals:**

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

### **Integrated Health Partnerships (ACO and TCOC Models)**

These models incentivized providers in ways that allowed them to share in savings for reductions in total cost of care (TCOC) for enrollees while maintaining or improving care quality and patient experience.

#### **Key ACO and TCOC Model Features:**

- Created flexible risk models for large integrated systems, smaller or independent providers, and other partner organizations to ensure the broadest participation possible.
- Worked within existing fee-for-service and managed care structures to allow faster implementation timelines and minimize enrollee disruption.
- Aligned with payment models in the commercial market and other emerging national models (i.e., Medicare Pioneer ACO and Shared Savings) to drive delivery system transformation where possible.

#### **IHP Goals:**

- To reduce the TCOC for Medicaid patients while maintaining or improving the quality of care.
- To assess whether an alternative care model will result in improvements to quality, cost, and experience of care.<sup>xlvii</sup>

#### **Emerging Professions**

The Emerging Professions Integration Program was part of the Practice Transformation goal of the Minnesota ACH Model – SIM testing grant. The plan calls for evaluation of each emerging profession for how its integration into a team environment changed the team's overall capacity and patient outcomes.

**Goal:** Expand the number of patients served by team-based integrated/coordinated care by supporting the adoption of emerging provider types.

#### **Focal Areas:**

- Community Health Workers
- Community Paramedics
- Dental Therapists/Advanced Dental Therapists

#### **Program Update (as of 2015)**

- 205,000 Minnesotans received care through an ACO (exceeds the 2016 goal).
- Minnesota certified 53% of health care homes and behavioral health homes (just short of the 2016 goal of 67%).
- IHPs produced \$61.5 million in cost savings (the 2016 goal was \$100 million).
- Minnesota achieved its goal of establishing 15 officially recognized ACH by 2015.
- An ACO or TCOC model (just short of the 2016 goal of 60 percent) covered 41 percent of fully insured covered lives in the commercial market. However, many plans reported less than 5 percent of their fully insured covered lives were attributable to ACOs.<sup>xlviii</sup>

## **VERMONT (ROUND 1, \$45 MILLION)**

FEBRUARY 2013 - JUNE 2017

**Goals:** The Vermont SIM plan sought to develop strategies that lead to a cohesive policy approach throughout the State, incentivized payment reform strategies that promote outcomes and sustainability, and empowered consumers to be agents in their own health plan.

To meet the health needs of the State's various communities, including rural communities and populations, the model emphasized (1) the expansion of advanced primary care practices through the State's Blueprint for Health initiative, and (2) payment reform models through ACOs that incentivize outcomes and quality through shared savings programs, performance-based pay, and bundled payments. With 61 percent of Vermont's population residing in federally defined rural regions, structural system reforms that improve quality through care integration and payment reforms will lead to improved health outcomes and patient satisfaction for underserved rural communities and populations.<sup>xlix,l,li</sup>

Vermont aimed to achieve the goals of its SIM plan through three models: a shared-savings ACO model that involves integration of payment and services across an entire delivery system; a bundled payment model that involves integration of payment and services across multiple independent providers; and a pay-for-performance model aimed at improving the quality, performance, and efficiency of individual providers. The SIM award also funded enhancements in health system infrastructure including improved clinical and claims data transmission, integration, analytics, and modeling; expanded measurement of patient experience of care; improved capacity to measure and address health care workforce needs; health system learning activities essential to spreading models and best practices; and enhanced telemedicine and home monitoring capabilities.

### **Active Work Groups**

In an effort to meet the goals of 'better care, better, health, and lower health care costs', the Vermont Health Care Innovation Project sought stakeholder input through various Work Groups that sought to provide recommendations for policy initiatives. Active Work Groups include:

#### **1. Care Models and Care Management**

The work group examined operating or planned care management programs and care delivery models. The group recommended mechanisms for assuring greater consistency and/or coordination across these programs and models in terms of service delivery, financial incentives, quality measurement, or other key model or program components. This includes PCMH, ACO, and Health Home models. The goal of these recommendations was to maximize effectiveness of the programs and models in improving Vermonters' experience of care, reducing unnecessary costs and improving health, and minimizing duplication of effort or inconsistencies between the models.<sup>lii</sup>

- As of first quarter 2015, Vermont reported that PCMHs reached 84% of both Medicaid and Medicare populations under the innovation models.
- Recognized PCHM included 694 unique providers and 63 provider organizations, representing 95% of primary care physicians and 37% of all physicians.
- ACOs reached 49% of the total Medicaid only population and 75% of the Medicare only population.
- ACOs included 52% of all active care physicians, in first quarter 2015.
- Health Homes included 123 physicians and 5 provider organizations; Health Homes reported no data on specific populations reached.<sup>liii</sup>

## **2. Disability and Long-Term Services and Supports**

The work group built on the extensive work of the State's dual eligible demonstration steering committee. The group continued to develop recommendations regarding the following:

- A care model or models for dually eligible Vermonters that improved beneficiary service and outcomes.
- Provider payment models that encouraged quality and efficiency among the array of primary care, acute, and long-term services and support providers who serve dually eligible populations.
- Quality measures used to evaluate provider and overall project performance.
- A financial model that allowed for an assessment of the potential costs, benefits, and risks of the project for the State, providers, and beneficiaries.
- Management structures necessary to administer the project at both the State and provider levels.<sup>liv</sup>

## **3. Health Care Workforce Specific to the Vermont Health Care Improvement Project**

The work group sought to gather the data necessary to assess supply and demand to ensure the appropriate number and type of health care professionals to achieve the project's goals. After obtaining and analyzing the data, the work group developed, recruited, and retained the workforce needed. This required intense and well-coordinated work that engaged the entire health care and educational community, including State entities and external stakeholders.<sup>lv</sup>

## **4. Health Information Exchange (HIE)**

### **HIE Work Group Accomplishments:**

- Identified the desired characteristics and functions of a high-performing statewide information technology system
- Explored and recommended technology solutions to achieve the SIM plan's desired outcomes
  - Guided investments in the expansion and integration of health information technology, as described in the SIM proposal, including the following:
  - Support for enhancements to EHRs and other source data systems to expand use of technology that supports integration of services and enhanced communication, including connectivity and data transmission from source systems such as mental health providers and long-term care providers
    - As of first quarter 2015, the State reported high EHR adoption rates: 100% in hospitals and home health providers, 97% among PCPs, and 90% among FQHCs.<sup>lvi</sup>
  - Implementation of and/or enhancements to data repositories
  - Implementation of and/or enhancements to data integration platform(s)
  - Development of advanced analytics and reporting systems

Going forward, the group also will advise the development of the State's Health Information Technology plan with regard to the above activities and expenditures.

**HIE Work Group Recommendations:**

- The HIE work plan (to the Steering Committee)
- Expenditure of SIM funds to support HIT investments
- Coordination of HIT/HIE-related efforts across various agencies and organizations
- Prioritization of new initiatives such as EHR installations, interfaces, and other investments

**5. Payment Models**

The work group builds on the work of the ACO standards work group to date and will do the following:

- Continue to develop and recommend standards for the State's commercial Shared Savings Program ACO (SSP-ACO) model
- Develop and recommend standards for the Medicaid SSP-ACO model
- Develop and recommend standards for both commercial and Medicaid episode-of-care models
- Develop and recommend standards for Medicaid pay-for-performance models
- Review the work of the State's dual eligible demonstration work group on payment models for dual eligible beneficiaries
- Recommend mechanisms for ensuring consistency and coordination across all payment models

**6. Population Health**

The work group examines current population health improvement efforts administered through the Department of Health, the Blueprint for Health, local governments, employers, hospitals, ACOs, Federally Qualified Health Centers and other provider and payer entities. The group examines these efforts and the State's SIM plan for their potential impact on the health of Vermonters and recommend ways in which the project could better coordinate health improvement activities and more directly impact population health, including the following:

- Enhancement of State initiatives administered through the Department of Health
- Support for or enhancement of local or regional initiatives led by governmental or non-governmental organizations, including employer-based efforts
- Expansion of the scope of delivery models within the scope of SIM or pre-existing State initiatives, to include population health

**7. Quality and Performance Measures**

The work group builds on the work of the ACO Quality and Performance Measures Work Group, and recommends standardized measures used as follows:

- To evaluate the performance of Vermont's payment reform models relative to State objectives
- To qualify and modify shared savings, episodes of care, pay for performance, and health home payments
- To communicate performance to consumers through public reporting



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- <sup>i</sup> Available at: <https://innovation.cms.gov/about/index.html>
- <sup>ii</sup> Van Vleet, A., Paradise, J., (2014, December). The State Innovation Models (SIM) Program: An Overview. Available at: <http://kff.org/medicaid/fact-sheet/the-state-innovation-models-sim-program-an-overview/>
- <sup>iii</sup> Available at: <https://innovation.cms.gov/initiatives/State-Innovations-Model-Testing/index.html>
- <sup>iv</sup> RTI International. State Innovation Models (SIM) Initiative Evaluation: Model Test Year Two Annual Report. August 2016. Available at: <https://downloads.cms.gov/files/cmimi/sim-round1-secondannualrpt.pdf>
- <sup>v</sup> Arkansas Center for Health Improvement. State Innovation Model Award: Program Overview. Available at: <http://www.achi.net/pages/OurWork/Project.aspx?ID=67>
- <sup>vi</sup> Arkansas Health System Transformation: State Innovation Plan. Available at: <http://www.achi.net/Content/Documents/ResourceRenderer.ashx?ID=82>
- <sup>vii</sup> Ibid
- <sup>viii</sup> (2012, September) Arkansas Health System Transformation: State Innovation Plan. Available at: <http://www.paymentinitiative.org/referenceMaterials/Pages/default.aspx>
- <sup>ix</sup> Arkansas State Innovation Model: Model Testing Proposal-Project Abstract. Available at: <http://www.paymentinitiative.org/referenceMaterials/Pages/default.aspx>
- <sup>x</sup> Arkansas State Innovation Model: Project Plan and Timeline. Available at: <http://www.paymentinitiative.org/referenceMaterials/Pages/default.aspx>
- <sup>xi</sup> Arkansas Center for Health Improvement. State Innovation Model Award: Program Overview. Available at: <http://www.achi.net/pages/OurWork/Project.aspx?ID=67>
- <sup>xii</sup> Arkansas Center for Health Improvement. Arkansas Health Care Payment Improvement Initiative: 2nd Annual Statewide Tracking Report January 2016 – Executive Summary. Available at: <http://www.achi.net/Docs/438/>
- <sup>xiii</sup> Ibid.
- <sup>xiv</sup> RTI International. State Innovation Models (SIM) Initiative Evaluation: Model Test Year Two Annual Report. August 2016. Available at: <https://downloads.cms.gov/files/cmimi/sim-round1-secondannualrpt.pdf>
- <sup>xv</sup> Arkansas Center for Health Improvement. Arkansas Health Care Payment Improvement Initiative: Second Annual Statewide Tracking Report January 2016 – Executive Summary.
- <sup>xvi</sup> Ibid.
- <sup>xvii</sup> Ibid.
- <sup>xviii</sup> What is SIM? Colorado.gov. Available at: <https://www.colorado.gov/healthinnovation/what-is-sim>
- <sup>xix</sup> CO SIM; Available at: <https://drive.google.com/file/d/0BxUiTIOWSbPUYkhmMFpPc210ZWw/view>
- <sup>xx</sup> Colorado State Innovation Model: Application for Funding. State of Colorado, July 2014. Available at: <https://drive.google.com/file/d/0BxUiTIOWSbPUSG1pVWJlaGgydJA/view>
- <sup>xxi</sup> Colorado SIM Operational Plan: Revised January 6, 2016. State of Colorado, January 2016. Available at: <https://drive.google.com/file/d/0BxUiTIOWSbPUY2xvRmNpX1JkMDg/view>
- <sup>xxii</sup> Colorado Health Extension System (CHES) Advancement Opportunities Catalog. 2015. Available at: <http://www.practiceinnovationco.org/wp-content/uploads/2016/02/2015-2016-Advancement-Opportunities-Catalog.pdf>
- <sup>xxiii</sup> <https://innovation.cms.gov/initiatives/State-Innovations-Model-Testing-Round-Two/index.html>
- <sup>xxiv</sup> Ibid.
- <sup>xxv</sup> *Idaho SIM Model Test Plan*. (2014) (1st ed., pp. 1-10). Available at: <http://healthandwelfare.idaho.gov/Portals/0/Medical/SHIP/IdahoModelTestOperationalPlan.pdf>
- <sup>xxvi</sup> "Idaho's Plan to Transform Its Healthcare System Earns Federal Grant for Almost \$40 Million > Idaho Department of Health And Welfare > Newsroom". *Healthandwelfare.idaho.gov*. N.p., 2014. Web. 11 Apr. 2016.
- <sup>xxvii</sup> (2012, September) Oregon Health Authority. Oregon Health Care Innovation Plan. Available at: <http://www.oregon.gov/oha/OHPR/Pages/sim/index.aspx>
- <sup>xxviii</sup> (2014, August) Oregon Health Authority. Oregon SIM Operational Plan. Available at: <http://www.oregon.gov/oha/OHPR/Pages/sim/index.aspx>.
- <sup>xxix</sup> *Oregon Health Policy and Research State Innovation Model Grant*. (2016). *Oregon.gov*. Available at: <https://www.oregon.gov/oha/OHPR/Pages/sim/index.aspx>
- <sup>xxx</sup> *Oregon Health Policy Board Coordinated Care Organizations*. (2016). *Oregon.gov*. Available at: <https://www.oregon.gov/oha/OHPB/pages/health-reform/ccos.aspx>
- <sup>xxxi</sup> Valentine, Jennifer. 2016. Personal communication.
- <sup>xxxii</sup> "Transformation Center Oregon". *Oregon.gov*. N.p., 2015. Web. 23 Apr. 2016.

- 
- <sup>xxxiii</sup> Interview with Jennifer Valentine, Oregon Health Authority.
- <sup>xxxiv</sup> CCO Oregon. Resources: Coordinated Care Organizations. Available at: <http://www.ccooregon.org/resources/ccos/>
- <sup>xxxv</sup> Columbia Pacific CCO. Join Our Community Advisory Council. Available at: <http://www.colpachealth.org/about-us/community-advisory-council>
- <sup>xxxvi</sup> *Quality and Accountability Oregon's Health System Transformation Coordinated Care Organizations Performance Reports*. (2016). Oregon.gov. Available at: <https://www.oregon.gov/oha/Metrics/Pages/HST-Reports.aspx>
- <sup>xxxvii</sup> *State Health Care Innovation Plan-Oregon CMMI SIM Model Testing Application*. (2012) (1st ed.). Available at: <http://www.oregon.gov/oha/OHPR/SIM/docs/Grantpercent20Document.pdf>
- <sup>xxxviii</sup> *Project Plan and Timeline- Oregon CMMI SIM Model Testing Application*. (2012) (1st ed.). Available at: <http://www.oregon.gov/oha/OHPR/SIM/docs/Grantpercent20Narrative.pdf>
- <sup>xxxix</sup> RTI International. State Innovation Models (SIM) Initiative Evaluation: Model Test Year Two Annual Report. August 2016.
- <sup>xl</sup> *Oregon's State Innovation Model Project Progress Report*. (2013) (1st Ed.). Available at: <http://www.oregon.gov/oha/OHPR/SIM/docs/SIMpercent20Progresspercent20Reportpercent20Oct-Decpercent202013.pdf>
- <sup>xli</sup> SIM Minnesota. Minnesota Accountable Health Model – SIM (2014). Available at: [http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_FILE&RevisionSelectionMethod=LatestReleased&Renderion=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16\\_197634](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Renderion=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_197634)
- <sup>xlii</sup> (2015, May) SIM Minnesota. Minnesota Accountable Health Model – Accountable Communities for Health. Available at: [http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_DYNAMIC\\_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=SIM\\_Fact\\_Sheets](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=SIM_Fact_Sheets)
- <sup>xliii</sup> SIM Minnesota. Health Reform Minnesota - E-Health. Available at: [http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_DYNAMIC\\_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=SIM\\_Ehealth](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=SIM_Ehealth)
- <sup>xliv</sup> (2015, October) SIM Minnesota. Minnesota Accountable Health Model – Emerging Professions. Available at: [http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_DYNAMIC\\_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=SIM\\_Fact\\_Sheets](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=SIM_Fact_Sheets)
- <sup>xlv</sup> (2013, February) Minnesota Accountable Health Model Executive Summary, Minnesota Health Innovation Plan. Retrieved from <http://mn.gov/health-reform/SIM/>
- <sup>xlvi</sup> (2015, May) SIM Minnesota. Minnesota Accountable Health Model – Accountable Communities for Health.
- <sup>xlvii</sup> (April 2016) SIM Minnesota. Minnesota Accountable Health Model – Integrated Health Partnerships. Available at: [http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_FILE&RevisionSelectionMethod=LatestReleased&Renderion=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16\\_197631](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Renderion=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_197631)
- <sup>xlviii</sup> Minnesota Accountable Health Model: How we are doing (July 2015). Available at: [http://www.dhs.state.mn.us/main/groups/sim/documents/pub/dhs16\\_196540.pdf](http://www.dhs.state.mn.us/main/groups/sim/documents/pub/dhs16_196540.pdf)
- <sup>xlix</sup> (2012, September) Vermont Health Care Innovation Project. Vermont Health Care Innovation Plan. Available at: <http://healthcareinnovation.vermont.gov/node/854>
- <sup>l</sup> (2013, July) State of Vermont. State Innovation Model Operational Plan for Health Care Innovation. Available at: <http://healthcareinnovation.vermont.gov/node/854>
- <sup>li</sup> (2014) State of Vermont Health Care Innovation Project. SIM Sub-grant Program. Available at: [http://healthcareinnovation.vermont.gov/VHCIP\\_Grant\\_Program](http://healthcareinnovation.vermont.gov/VHCIP_Grant_Program)
- <sup>lii</sup> Available at: [http://healthcareinnovation.vermont.gov/work\\_groups/care](http://healthcareinnovation.vermont.gov/work_groups/care)
- <sup>liii</sup> RTI International. State Innovation Models (SIM) Initiative Evaluation: Model Test Year Two Annual Report. August 2016.
- <sup>liiv</sup> (May 2016) National Organization of State Offices of Rural Health. A Report on the Role of SORHs with State Innovation Model (SIM) Programs. Available at: [https://nosorh.org/wp-content/uploads/2013/07/The-Role-of-SORHs-with-State-Innovation-Models\\_May-2016.pdf](https://nosorh.org/wp-content/uploads/2013/07/The-Role-of-SORHs-with-State-Innovation-Models_May-2016.pdf)
- <sup>liv</sup> Ibid.
- <sup>lvi</sup> RTI International. State Innovation Models (SIM) Initiative Evaluation: Model Test Year Two Annual Report. August 2016.