DRAFT State Health Care Innovation Plan

October 10, 2013

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LETTER FROM SECRETARY DOOLEY

In December 2012, Co-Chair Donald Berwick, M.D., and I released the "Let's Get Healthy California" Task Force report, the product of six months of intense work by dozens of California's health and health care leaders. The Task Force's charge was ambitious—envision what California will look like in ten years if we commit to becoming the healthiest State in the nation. The result was a framework for assessing Californians' health across the lifespan, with a focus on Healthy Beginnings, Living Well, and End of Life. The Task Force also identified three pathways for change: Redesigning the Health System, Creating Healthy Communities, and Lowering the Cost of Care. Importantly, the report made clear that eliminating health disparities was critical to achieving our goals.

With that as a foundation, we once again turned to the vast expertise and creativity in our State to help design a plan that will implement significant health system and payment reforms. The State Health Care Innovation Plan (SHCIP) was prepared with support from the federal government and designed to meet the requirements of a State Innovation Model design grant. Moreover, it balances the need to realize savings over the next three years with the longer-term goal of accelerating broader public and private sector health care transformations.

Our Task Force set an overall target of bringing California's health care expenditures growth rate in line with that of the gross state product (GSP) by 2022, along with establishing targets for each of the other 38 health indicators. The SHCIP includes advancements toward these two goals, as well as a third goal of increasing payments that reward performance.

Tracking progress on all of these goals is critical, and the Innovation Plan provides an important vehicle to do this. To account for California's geographic scale and variation, regional performance targets will be set in addition to the statewide targets. Metrics will be reviewed annually and made public through a report. I, along with leadership from our major state purchasers (California Public Employees' Retirement System, Covered California, and the Department of Health Care Services), as well as from private purchasers through the Pacific Business Group on Health, will visit and meet with key partners and stakeholders in each region to conduct these reviews. Given its considerable investments in California and sizeable market share, it is critical that the Centers for Medicare and Medicaid Services be at the table as well.

The Plan presented here centers around four initiatives, which focus on different aspects of the health care system that experience particularly high costs—uncoordinated care for people with complex chronic conditions, maternity care, and end of life care. Through the greater use of team-based care and care coordination (including linking with community and social services), implementation of best practices, incorporation of lower-cost health providers where appropriate, and respecting patient preferences for care options, these initiatives will lower costs while improving health outcomes.

The plan also includes six building blocks, which will enhance the success of the initiatives and position the state for long-term continuous improvement. Several of the building blocks—workforce enhancements, health information technology and exchange, and enabling authorities—directly support the initiatives. Importantly, the other building blocks—development of an All Payer Claims Database, public reporting of data, and supporting a payment reform innovations incubator—will promote greater transparency and accountability in support of system-wide efforts to bend the cost

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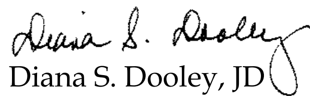
curve. In total, these activities will enable California to track costs and quality across diverse systems of care, promote competition, and accelerate the spread of successful initiatives.

Taken together, these initiatives and building blocks form a cohesive plan that leverages current momentum, targets interventions where we can obtain real results and savings in three years, and puts California on the road to achieving our long-term goals set out in the Let's Get Healthy California report.

I am indebted to the Co-Chair of the planning process, Tom Williams, Executive Director of the Integrated Healthcare Association, the co-chairs and participants of each of the work groups, and the numerous State staff and consultants who have given so generously of their time and talent to develop this report. I continue to be grateful for their commitment and leadership as work toward our vision to be the healthiest State in the country.



Diana S. Dooley, JD
Secretary
California Health and Human Services Agency

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ACKNOLWEDGEMENTS

Thank you to the Center for Medicare and Medicaid Innovation for providing financial and technical assistance support for this report. Deep appreciation is also extended to the Blue Shield of California Foundation and The California Endowment for their leadership and for supporting our California State Innovation Model (CalSIM) stakeholder and planning process prior to the federal award, and to the California Health Care Foundation for its leadership and generous technical assistance.

Our sincere appreciation is extended to the Work Group Co-Leads and each work group member whose invaluable skills and expertise informed the initiatives and building blocks laid out in this report. Also, we are thankful for all of the state staff and consultants who advised and provided information for this work. A full list of work group co-leads, key staff, work group members, and consultants can be found in an Appendix.

We extend our gratitude to the staff at the Institute for Population Health Improvement at the University of California, Davis, the California Health and Human Services Agency, and the Department of Social Services who assisted with our many contracts.

Special thanks to the California Public Employees' Retirement System, Kaiser Permanente Garfield Innovation Center, and the Sutter Center for Health Professions, and their talented staff for hosting our in-person meetings. Also, appreciation goes to the California Department of Health Care Services information technology team which made our webinars possible from January until May.

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Executive Summary

On April 1, 2013, the State of California was awarded a State Innovation Model (SIM) Design Grant from the federal Center for Medicare and Medicaid Innovation (CMMI). The grant is supporting California to develop a State Health Care Innovation Plan (SHCIP), which will form the basis of a forthcoming application for a three-year State Innovation Model Testing grant. The SHCIP must address all three aspects of the Triple Aim – better health, better health care, and lower costs, demonstrate a return on investment within the three-year time frame, include a broad array of stakeholders and multiple payers, affect a preponderance of care, and leverage existing initiatives and investments.

In anticipation of receiving the Design grant, California Health and Human Services Secretary Diana Dooley convened six work groups in March 2013 to begin developing proposed reforms for potential inclusion in the SHCIP. The work groups were based on the goals identified by the Let's Get Healthy California Task Force report, issued in December 2012: Healthy Beginnings, Living Well, End of Life, Redesigning the Health System, Creating Healthy Communities, and Lowering the Cost of Care.

The three-year time frame of the SHCIP is far shorter than the 10-year plan envisioned by the LGHC Task Force. For this reason, the SHCIP focuses on initiatives designed to achieve savings in the short-term, but which also set in motion changes that will advance transformation over the long term. These initiatives build on efforts currently underway and are to be viewed in conjunction with other reforms both in the public sector and the private sector marketplace. Specifically, the SHCIP establishes three overarching goals:

- *Demonstrate significant progress toward reducing health care expenditures which places California on a path to achieve the LGHC ten-year goal of bringing the health care expenditure growth rate in line with the gross State product by 2022;*
- *Increase value-based contracts that reward performance and reduces pure fee-for-service reimbursement; and*
- *Demonstrate significant progress on the LGHC Dashboard, especially those indicators related to the proposed initiatives included in the SHCIP.*

The SHCIP is designed to bring together leadership from California's public purchasers—the California Public Employees' Retirement System, Covered California, and the Department of Health Care Services, along with large employers from the Pacific Business Group on Health, to jointly implement the key initiatives outlined in this plan. Given its significant investment in California and sizeable share of the market, it is also critical that the Centers for Medicare and Medicaid Services participate as a partner in the SHCIP's implementation. Together these purchasers and their payer partners represent close to 80 percent of all California health expenditures, enabling the SHCIP to have a significant influence in aligning incentives across payers toward greater value, quality, and improved outcomes

The SHCIP is conservatively projected to yield savings of $1.3 to $1.7 billion over three years—a return of over 20-fold on the potential $60 million SIM investment. It is likely that the SHCIP initiatives will continue to produce savings in subsequent years, as the initiatives take hold and spread, and greater transparency shines a spotlight on high and low performing systems.

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In order to achieve savings of this magnitude—while improving health outcomes—public, private, and nonprofit healthcare leaders will need to be vigilant in tracking and monitoring progress. Because of the significant variation in health care costs and prices, as well as the level of clinical and organizational integration, quality of care, and health outcomes across the State, three-year targets at both the State *and* regional level will be established. An annual progress report will be issued and reviewed publicly statewide by the Let's Get Healthy California Task Force and at a more refined level by region.

To promote transparency, accountability, and healthy competition, the Secretary of Health and Human Services, the directors of the major state public purchasers, along with private employer representatives, the Integrated Healthcare Association, and hopefully federal representatives, will host annual regional meetings with heads of hospitals, health plans, county health departments, physician groups, and others, such as local employers and State elected officials representing each region. These public meetings will be a forum for reviewing progress for regional metrics related to both the preceding overarching targets and the specific initiatives described in this plan. The meetings will also be an opportunity for information sharing regarding efforts that are demonstrating early success as well as those metrics and systems that are lagging, enabling corrective action to be taken midstream.

The SHCIP is organized into two main strategic components: (1) **Initiatives**, which include four targeted health system and payment reforms; and (2) **Building Blocks**, which directly support the four initiatives, as well as enhance overall data, transparency, and accountability efforts necessary to accelerate transformation throughout the State.

The initiatives (listed below), center on care coordination, including team-based care and linking with community-based programs, because it is central to achieving the vision of an efficient, high quality, and seamless health system.

- ***Maternity Care.*** Promote safe, evidence-based deliveries to improve birth outcomes, promote maternal and infant health, and reduce unnecessary costs.
- ***Health Homes for Complex Patients.*** Implement and spread care models, which include coordinated, team-based care, to improve the quality of care and outcomes for medically complex patients, and reduce costs associated with unnecessary emergency department visits and hospitalizations.
- ***Palliative Care.*** Promote the use of palliative care, when appropriate and in line with patient preferences, by educating patients, training providers, and removing any structural or informational barriers to receiving care.
- ***Accountable Care Communities.*** Support development of two or three Accountable Care Community pilots that will model how population health can be advanced through collaborative, multi-institutional efforts that promote a shared responsibility for the health of the community. Pilots will include a Wellness Trust, serving as a vehicle to pool and leverage funding from a variety of sources for long-term sustainability.

The **building blocks** (listed below) address the needed capacities and supports for health and health care transformation and payment reforms to succeed. In addition, to sustain the transformation process over the long term, building blocks are included that address data,

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transparency, and accountability issues on a system-wide basis. The goal of these building blocks is to enable California to track costs and quality across diverse systems of care, promote transparency and competition, and drive continuous improvement.

- ***Workforce* -** Leverage and advance existing efforts to deliver team-based, culturally engaged health care services, focusing on support for training and technical assistance of key health personnel, including enhancing the ability of community-based health and other lower-cost workers to play a role, where appropriate.
- ***Health Information Technology and Exchange* -** Target technical assistance to high-need entities and geographies developing health homes for complex patients and support research and analysis, including business case analyses, related to the take-up and spread of health technologies and data collection.
- ***Enabling Authorities* -** Identify and secure needed policy changes that either remove barriers or create incentives to achieve the goals of the SHCIP. Because the initiatives proposed in the SHCIP build off of existing innovations and initiatives underway in California, most can be implemented without significant legislative and regulatory changes. Two requests for Medicare waivers are included.
- ***All-Payer Claims Database (APCD)* -** Build on current efforts to create an integrated data system that will support comprehensive data collection, analysis, and utilization of data in order to enable comparisons of costs, performance, and outcomes across all populations, providers, and regions of the State.
- ***Public Reporting* -** Enhance State efforts to make data on health care quality costs and population health—especially focusing on LGHC goals and indicators—readily available and accessible to stakeholders and the general public.
- ***Payment Reform Innovation Incubator* -** Support an expanded private-public forum to facilitate payers, providers, and purchasers to build consensus regarding methods for developing and implementing new payment reform methods and for calculating costs and impacts of payment reforms.

The SHCIP is designed to take advantage of California's history of innovation and leadership. It leverages public and private sector reforms already underway by scaling up promising practices and seeding further innovation. Through collaboration begun in the LGHC Task Force, the SHCIP will help catalyze further progress to reduce the growth rate of health care expenditures and firmly place California on the road to become the healthiest State in the country.

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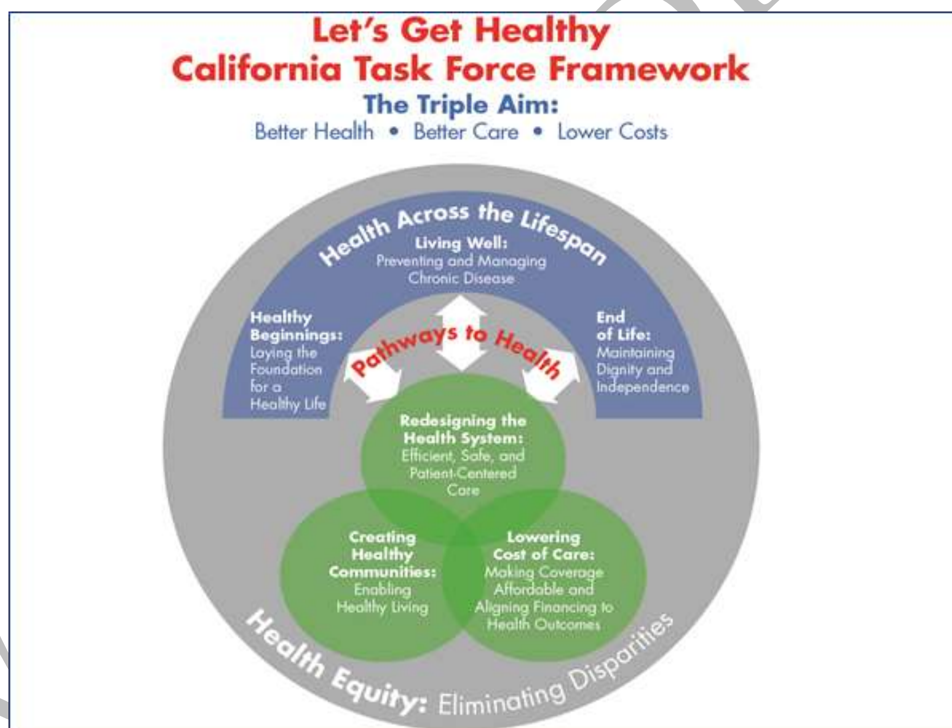
I. Introduction and Overview of California's State Health Care Innovation Plan

On May 3, 2012, Governor Jerry Brown issued an executive order establishing the Let's Get Healthy California (LGHC) Task Force to develop a 10-year plan with the goals of improving health, controlling costs, addressing health disparities, and promoting personal responsibility for health among the population. In December 2012, the LGHC Task Force issued a report outlining recommendations for making California the healthiest State within the next 10 years.[1] The framework, based on the Triple Aim, depicts two strategic directions—Health Across the Lifespan and Pathways to Health. As shown in **Figure I.1,** under the first strategic direction, there are three goals which align with three critical life stages (childhood, adulthood, end of life), while the second strategic direction covers the changes required to improve the quality and efficiency of the health system, make community environments more conducive to health, and lower costs. The LGHC Task Force report also stresses integration of health equity across the entire effort. As the most diverse state in the country, California can only become the healthiest state in the nation if health disparities are reduced and, ultimately, eliminated.

Figure I.1: Let's Get Healthy California Task Force Framework



The goals and priorities set forth by LGHC serve as the foundation for the State Health Care Innovation Plan (SHCIP) developed under a Centers for Medicare and Medicaid Innovation (CMMI) State Innovation Models (SIM) Design award. The SHCIP is designed to meet the requirements of a State Innovation Model Testing grant. Testing grant criteria include using a multi-payer approach to demonstrate a return on investment within three years, reach a preponderance of Californians, and build upon existing initiatives. A proposal, based on the SHCIP, will be submitted to CMMI once the announcement of funding availability is made, likely in early 2014.

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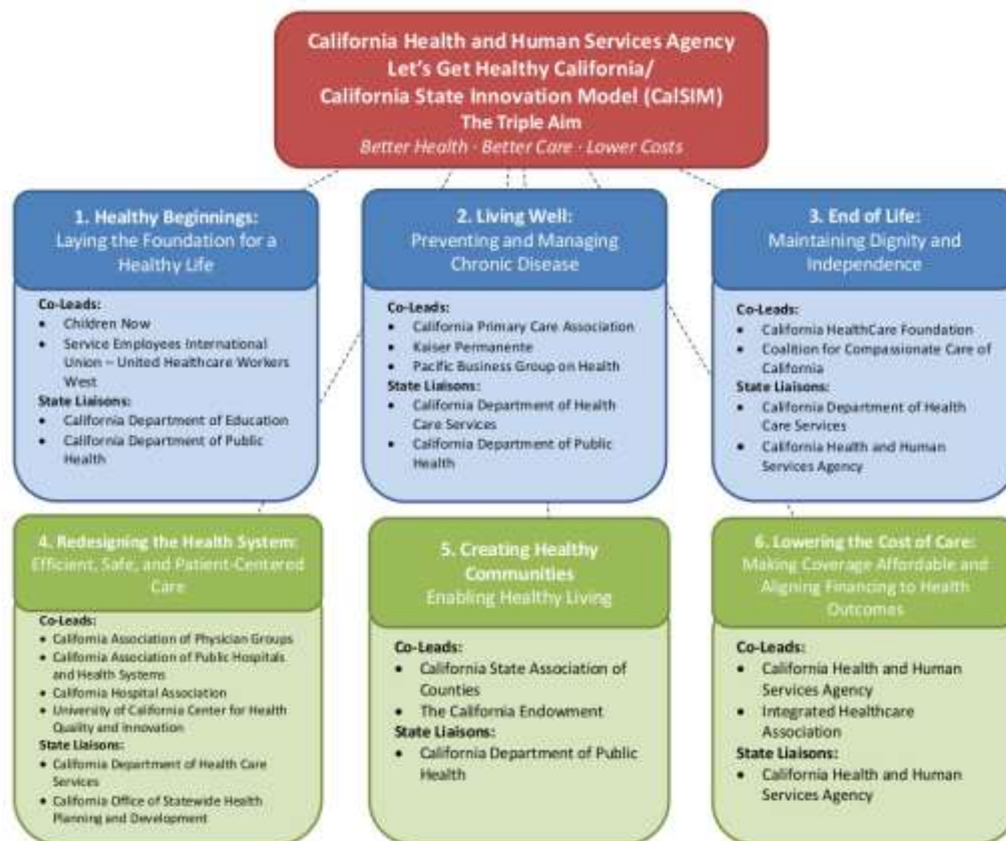
In anticipation of the award of the Design grant, in January 2013, California Health and Human Services (CHHS) Secretary Diana Dooley authorized the creation of six work groups, corresponding to each of the six goals from the LGHC report. Co-Lead organizations were selected for the six work groups; these Co-Leads then selected six to eight member organizations (see **Figure I.2**). These work groups, which began convening in March, consist of members of state and local health agencies, state health information technology (IT) coordinators, providers, payers, consumers, public health and community leaders, university medical centers, and other social and health care organizations (see **Appendix I**). During the first quarter of the Design grant, each work group submitted payment reform and public policy recommendations to be considered for inclusion in California's State Health Care Innovation Plan (SHCIP). Work groups were also tasked with developing private sector recommendations to complement the payment reform and public policy recommendations.

In addition to the State of California and the state's many committed private sector stakeholders, the Centers for Medicare and Medicaid Services will be an essential partner in ensuring the SHCIP's success. Medicare represents 22 percent of all spending in the state and currently sponsors many innovations to move toward value-based payments and better care delivery in California. Aligning Medicare's purchasing strategies with those of the California Public Employees' Retirement System, Covered California, the Department of Health Care Services, and private employers is foundational to the Innovation Plan. Jointly these purchasers and their payer partners represent close to 80 percent of all California health expenditures.

Figure I.2: Let's Get Healthy California Task Force Framework



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The California SHCIP identifies key leverage points and opportunities to accelerate progress. While the three-year timeframe of the SHCIP is shorter than the 10-year plan envisioned by the LGHC Task Force, the SHCIP represents a significant gateway to the full range of system transformations needed to achieve the 10-year goals. For this reason, the SHCIP has dual goals: it focuses on initiatives designed to achieve savings in the short-term, but also sets in motion an accountability structure and changes that will advance long-term goals.

A. State and Regional Goals and Targets

The LGHC report sets an overall target of bringing the health care expenditures growth rate in line with the gross state product (GSP) by 2022, along with established targets for each of 38 health indicators. Due to California's geographic scale and variation, regional performance targets will also be set. **Table I.1** illustrates these variations by payer type: Commercial, Medicare Fee-For-Service (FFS), Medicare Advantage, and Medi-Cal. *Within each of these categories (not across categories)* the five regions are labeled as High, Medium, or Low in terms of health spending relative to each other. For example, in the Los Angeles region commercial spending is relatively low compared to commercial spending in other regions in California. However, for both Medicare FFS and Medicare Advantage, health spending per beneficiary in the Los Angeles area is relatively high, while Medi-Cal spending is ranked as medium, relative to other regions within Medi-Cal.

Table I.1 Health Care Spending per Beneficiary (2010) By Payer Type

Region	Commercial	Medicare FFS	Medicare Advantage	Medi-Cal
Bay Area, Sacramento	High	Low	Medium	High
Central Coast, Central Valley, North	Medium	Low	Low	High
Inland Empire	Low	Medium	Medium	Medium
Los Angeles	Low	High	High	Medium
Orange County, San Diego	Medium	Medium	Medium	Low

NOTE: Expenditure classes reflect variation within each insurance category and cannot be used to compare absolute spending differences between different types of insurance.

Sources: Commercial, IHA TCC Metric; Medicare, Commonwealth Fund; Medicaid, DHCS (Total FFS Paid/Number of Beneficiaries); Access, Office of the Patient Advocate and IHA

Appendix II contains county-specific information on cost, quality, and the degree of medical group integration. Further analyses are needed to determine appropriate regions for purposes of the SHCIP's performance review, and the degree of clinical (versus organizational) integration within them.

A combination of payment and delivery system reforms are needed across the entire system to achieve these goals. Therefore, it will be critical to monitor progress during the three-year timeframe, both overall and specific to SHCIP initiatives. The SHCIP provides an important

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vehicle to track California's cumulative efforts and ensure that the state is on pace to achieving its goals. These include:

1. ***Demonstrate significant progress toward reducing health care expenditures regionally and statewide to achieve the LGHC ten-year goal.*** The SHCIP is projected to yield savings of $1.3 to $1.7 billion over three years—a return of over 20-fold on the potential $60 million SIM investment. Three-year targets at both the state and regional levels will be established to assess the extent of overall progress. It is likely that the SHCIP initiatives will continue to produce savings in subsequent years, as the reforms take hold and spread, and as greater transparency shines a spotlight on areas of high and low performance. However, as significant as these savings are, they should be viewed as a down payment on the overall goal set by LGHC, which will require California's Annual Growth Rate for health care expenditures to be in line with rate of growth in gross State product by 2022. Together with numerous other private and public sector initiatives, the SHCIP will help catalyze statewide efforts to reduce the growth rate of health care expenditures.
2. ***Increase value-based contracts that reward performance and reduces pure fee-for-service reimbursement.*** There is general consensus that fee-for-service (FFS) reimbursement preserves financial incentives contrary to efforts to improve efficiency, value, and quality. Therefore, a key payment reform goal is to reduce the use of pure FFS as a payment mechanism and achieve more widespread adoption of performance-based payments. There are a variety of payment reforms that promote better alignment of the health delivery system with the values and principles described below. The SHCIP payment innovations include blended payments, requirements for payers to institute innovations such as shared savings, full or partial expanded capitation with providers, expanded pay-for-performance program participants and metrics, and wellness trust pilots as a vehicle for supporting upstream prevention and community health. This is not a call for sweeping global capitation at the delivery system level in the near term as (a) some providers are not prepared to accept global capitation and (b) purchasers are concerned that global capitation trends in California have increased provider consolidation and in turn raised prices through market exertion. Rather, the SHCIP will involve obtaining consensus on certain value-based payments for key initiatives and hopes to stimulate marketplace reforms by holding payers and providers accountable for tangible payment innovations that serve the Triple Aim.
3. ***Demonstrate significant progress on the LGHC Dashboard, especially those indicators related to the proposed initiatives described below.*** The six goals of the LGHC report provide the overarching framework for the SHCIP; the work groups, which made recommendations for the SHCIP, were organized around the LGHC goals. Therefore, it is anticipated that the initiatives will cumulatively influence and advance many of the indicators identified in the LGHC Dashboard. The LGHC indicators most associated with each initiative are noted in their respective sections of the report.

B. Accountability: Annual Review and Report on State, Regional, and Delivery System Performance

Key to the success of the SHCIP and to bending the cost curve over the long-term is accountability. California's public purchasers, including the California Public Employees' Retirement System, Covered California, and the Department of Health Care Services, along with the Centers for Medicare and Medicaid Services (requested), as well as the employers from

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the Pacific Business Group on Health, will implement and monitor the key initiatives outlined in this plan.[2] Led by the Secretary of Health and Human Services, the directors of these programs, along with the Integrated Healthcare Association, will host annual regional meetings with heads of hospitals, health plans, county health departments, physician groups, and others. Local employers and state elected officials representing each region will also be invited. These public meetings will serve as a forum for reviewing regional metrics related to the preceding overarching targets as well as the specific initiatives described in this Plan. The meetings will also provide an opportunity for information sharing regarding efforts that are demonstrating early success and those metrics and systems that are lagging, enabling corrective action to be taken midstream.

Most important, the meetings will provide an opportunity to examine cost and price variations and the drivers behind them. As described in **Figure I.3** (see next section), fostering healthy competition and creating transparency are two of the values that underpin the SHCIP. As mentioned, both private and public major purchasers are concerned about the considerable delivery system consolidation that has occurred in California's marketplace - and its subsequent affect on prices. By analyzing data at the delivery system level, such as total costs of care, it may be possible to shed greater light on factors that significantly contribute to this variability.

C. Vision, Values, and Guiding Principles

An ambitious and shared vision is the critical first step to engaging all stakeholders, particularly commercial payers, in a long-term effort to align the public and private sectors around the dual pillars of transformation: payment reform and delivery system reform.[3] These two pillars aim to move the system away from paying for the volume of health care services and towards paying for value. The vision of the SHCIP for health system transformation is as follows: "*California is home to high quality, efficient, seamless health systems throughout the State, which improve health outcomes for all Californians*."

The enumerated Values and Guiding Principles, displayed in **Figure I.3** have guided the planning process for the SHCIP. In addition to focusing on issues related to quality, efficiency, and coordination, the Values and Guiding Principles emphasize the importance, given California's size and diversity, of balancing consistency with flexibility in implementation. Moreover, transparency of clinical and administrative information is highlighted because it is critical to promote consumers' ability to make informed decisions and promote competition in the health care marketplace. Lastly, the Values and Guiding Principles reiterate California's commitment to achieving greater equity across populations that differ based on race, ethnicity, income, educational attainment, geography, sexual orientation and gender identity, and occupation.

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Figure I.3: SHCIP Target, Vision, Values and Principles

D. Overview of Initiatives and Building Blocks

The SHCIP is organized into two main strategic components, as depicted in **Figure I.4**:

1. **Initiatives**, which include four targeted health system and payment reforms; and
2. **Building Blocks**, which include three building blocks that directly support the four initiatives, as well as three system-wide efforts that enhance overall data, transparency, and accountability efforts, which are necessary to accelerate transformation beyond the four initiatives and beyond the time frame for the SHCIP.

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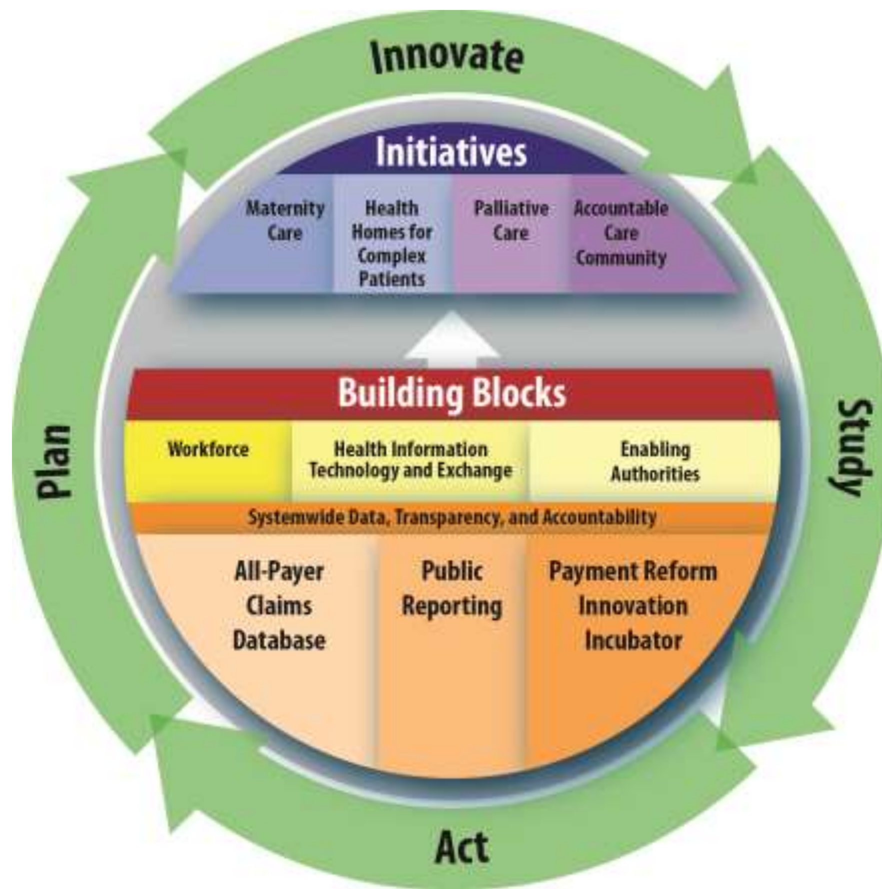
Figure I.4: SHCIP Framework



1. *Initiatives for Delivery System Transformation*

The SHCIP includes a limited set of interventions to drive delivery system reforms and financing changes that will sustain them over the long-term. While these initiatives are designed to achieve savings within the three-year timeframe of CalSIM, they also lay the groundwork for the longer-term transformation envisioned by the LGHC Task Force.

In developing these initiatives, the SHCIP stratifies potential populations targeted by the interventions. Because of the need to demonstrate cost savings, the majority of the initiatives focus on high-risk and high-cost populations. While these individuals comprise a relatively small percentage of the total population, they consume a significant share of health care resources. In California, five percent of the population accounts for over half of expenditures in a typical year.[4] Moreover, by focusing on high-risk populations, the SHCIP enables California to bring greater attention to these populations, in particular racial and ethnic populations that suffer from the greatest health disparities.

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Three populations, in particular are the focus of the SHCIP's initiatives:

First, the SHCIP targets individuals with complex health needs, particularly those who suffer from multiple chronic conditions and who represent the most costly 5 percent of a purchaser or payer population. For Medicare, the percentage, however, may be higher. Nearly 35 percent of California's Medicare beneficiaries representing 77 percent of expenditures experience four chronic conditions.[5] Because in many cases, care is uncoordinated and non-patient centered, innovations targeting these groups can achieve both improved outcomes and reduced costs in a relatively short period of time.

The SHCIP also includes efforts aimed at the two periods of life that are associated with the highest overall health care expenditures: maternity and end of life care, as shown in **Figure I.5**.[6] As the figure shows, health care costs in the last year of life comprised more spending than all health care costs up to that point in 2006. Since 2006, spending on health care towards the end of life may have increased. Per capita Medicare spending during the last two years of life increased by 15.2 percent ($60,694 to $69,947) between 2007 and 2010, while the consumer price index increased only 5.3 percent.[7] A significant proportion of these expenditures can be reduced while improving quality of care and outcomes.

Figure I.5. Health Care Expenditures Over the Lifespan

The four proposed initiatives will implement reforms in both service delivery and payment methods with the goal of continuing to incent the transformation process. Care coordination, including team-based care and linking with community-based programs, is the common strategy throughout these four initiatives because it is central to achieving the vision of an efficient, high quality, and seamless health system. The initiatives are:

- *Maternity Care*. Promote safe, evidence-based deliveries to improve birth outcomes, promote maternal and infant health, and reduce unnecessary costs.
- ***Health Homes for Complex Patients***. Implement and spread care models, which include coordinated, team-based care, in order to improve the quality of care and outcomes for medically complex patients and reduce costs associated with unnecessary emergency department visits and hospitalizations.

- ***Palliative Care***. Promote the use of palliative care, when appropriate and in line with patient preferences, by educating patients, training providers, and removing any structural or informational barriers to receiving care.
- ***Accountable Care Communities***. Support development of two or three Accountable Care Community pilots that will model how population health can be advanced through collaborative, multi-institutional efforts that promote a shared responsibility for the health of the community. Pilots will include a Wellness Trust, serving as a vehicle to pool and leverage funding from a variety of sources for long-term sustainability.

In advancing these initiatives, the SHCIP aims to achieve multi-payer implementation, but recognizes that not all of the target populations comprise significant percentages of different purchasers' beneficiary pools**. Table I.2** shows which initiatives target each population by purchaser/payer type. For each population and payer combination, evaluation measures will cover both costs and quality, stratified by managed care status.

Table I.2: System Transformation Initiatives, Populations, and Purchasers/Payers

Initiative	Target Population		Major Purchasers/ Payers				
			CalPERS	Covered CA	Medi-Cal Managed Care	Medicare	Other-Commer-cial
Maternity Care	Pregnant women and newborns		X	X	X		X
Health Homes for Complex Patients	Persons with more than one chronic condition	Dually eligible			X	X	
		Other complex patients	X	X	X	X	X
Palliative Care	Persons near the end of life	Dually eligible			X	X	
		Other	X	X	X	X	X
Accountable Care Communities	Persons with or at risk for asthma, diabetes, and/or cardiovascular disease		X	X	X	X	X

2. *Building Blocks*

The building blocks address the needed capacities and supports for health and health care transformation and payment reforms to succeed. Because the demands for health information technology and exchange, as well as workforce investments are wide-ranging, the SHCIP focuses on those efforts that can most directly impact and advance the four initiatives outlined

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above. Similarly, any required changes in authorities proposed here are limited to those that directly support the four initiatives.

In addition, building blocks are included that address data, transparency, and accountability issues on a system-wide basis, with the overarching goal of enabling California to track costs and quality across diverse systems of care, promote competition, and drive continuous improvement. These building blocks, such as the All-Payer Claims Database, will be particularly useful to the longer-term efforts, consistent with the LGHC report, to bend the cost curve. Moreover, these efforts should enable the collection and dissemination of data related to many of the indicators identified in the LGHC Task Force report to support the evaluation of initiatives advanced in the SHCIP, as well as other metrics identified in this report. These building blocks include the following.

- ***Workforce*** - Leverage and advance existing efforts to deliver team-based, culturally engaged health care services, focusing on support for training and technical assistance of key health personnel, including enhancing the ability of community-based health and other lower-cost workers to play a role, where appropriate.
- ***Health Information Technology and Exchange*** - Target technical assistance to high-need entities and geographies developing health homes for complex patients and support research and analysis, including business case analyses, related to the take up and spread of health technologies and data collection.
- ***Enabling Authorities -*** Identify and secure needed changes in authority that either remove barriers or create incentives to achieve the goals of the SHCIP. Because the initiatives proposed in the SHCIP build off of existing innovations and initiatives underway in California, most can be implemented without significant legislative and regulatory changes.
- ***All-Payer Claims Database (APCD)*** - Build on current efforts to create an integrated data system that will support comprehensive data collection, analysis, and utilization of data in order to enable comparisons of costs, performance, and outcomes across all populations, providers and regions of the State.
- ***Public Reporting*** - Enhance State efforts to make data on health care quality costs and population health—especially focusing on LGHC goals and indicators—readily available and accessible to stakeholders and the general public.
- ***Payment Reform Innovation Incubator*** - Support a private-public forum to facilitate payers, providers and purchasers to build consensus regarding methods for developing and implementing new payment reform methods and for calculating costs and impacts of payment reforms.

E. Conclusion

The SHCIP aims to accelerate transformations in health care to a vision characterized by efficient spending, high performance, and improved health outcomes for all Californians. The specific initiatives and approaches advanced in the SHCIP build upon the strengths of the current system and leverage the initiatives already underway to move the health care system towards the future vision. California is a large and diverse state with multiple health care sub-systems. Some areas have a high concentration of physicians and hospitals, with considerable

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competition, while in other areas, providers are in very short supply. Significant swaths of the State are rural, but the population is concentrated in urban areas. Assuming that a singular health care delivery system model can be effective in vastly different markets is neither realistic nor appropriate. Rather, common principles and goals will drive reforms, recognizing that different approaches may be needed to achieve them.

Therefore, the initiatives in the SHCIP are flexible and adaptable to different circumstances, while engaging and incentivizing payers to align toward a common set of goals. These individual initiatives in conjunction with the building blocks form a cohesive plan to achieve the State's vision. California's creativity and innovation thrive when challenged, and the SHCIP is an important tool to support the State in achieving its long-term goals set by the LGHC Task Force.

II. Description of California's Health Care Environment

With a population of just over 38 million in 2012, California is the most populous state, accounting for 12 percent of the total U.S. population.[8] Due to its size and unique demographic profile, California offers fertile grounds for testing the innovations proposed in the SHCIP. This section provides an overview of the California health care environment, including a discussion of population health, costs, performance, and quality in California's health care system. The section also includes a summary of the health care market and examples of initiatives and demonstrations underway relevant to the SHCIP initiatives. Further discussion of the California health care environment can be found in a companion document entitled, **California Market Assessment** and in **Appendix III**.

A. Population Health

The demographic composition of the State is, in many ways, unique compared with the U.S. overall. California is currently the sixth youngest state, with a median age of 35 years compared to a national average of 37 years. However, its population is projected to age at a faster rate than the U.S. average – the population age 65 and older is expected to nearly double over the next twenty years.[9] The large non-elderly adult population provides an opportunity to test innovations covered under private insurance or Medi-Cal; while the rapidly aging population provides an impetus to develop new methods for improving care provided to Medicare enrollees.

Given the disproportionate number of young people in California, it is not surprising that, on many measures, the California population appears to be in good health relative to the nation as a whole. Across the State, 85 percent of California residents report that their health status is good, very good, or excellent, which is slightly higher than the national rate (83 percent). In fact, across many of the LGHC indicators, California's data compare similarly or favorably to national data. The LGHC report assessed Californians' health across the lifespan, considering three periods of life: healthy beginnings, living well, and end of life. These measures show that California has a lower infant mortality rate than the national average, more individuals meeting physical activity guidelines, fewer smokers, and fewer obese adults.[10] Despite these positive indicators, California faces an array of population health challenges and opportunities related to an aging population and end of life care, children's health status, prevalence of chronic

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conditions, health disparities among socio-economic and racial/ethnic groups, and escalating health care costs. For a more detailed explanation of these issues, see **Appendix III**.

B. Health Care Costs

Due to high managed care penetration, a relatively young population, a high uninsured rate, and low Medi-Cal payment rates, California's per capita health spending is below the national average and the ninth lowest in the nation ($6,238 compared to $6,815 nationally in 2009). Medi-Cal per capita spending falls significantly below the national average ($4,569 compared to $6,826 in 2009) while California Medicare per capita spending is higher than the national average ($10,954 compared to $10,365 in 2009).[11] Medicare comprises 22 percent of total health spending. Medi-Cal comprises 17 percent, and the remainder is paid by private and other government payers (2009).[12]

Within any health care cost distribution, costs are highly skewed and largely attributable to a small number of enrollees consuming the majority of health care dollars. In California, across all payers, five percent of the population accounts for over half of expenditures in a typical year.[13] Identifying the individuals contributing disproportionately to health care costs is critical to implementing successful cost containment strategies. Moreover, since high costs may imply inefficient, inappropriate, or ineffective health care in certain circumstances, policies targeting high-cost individuals have the potential to improve quality.

As shown in **Figure I.5**, very often individuals experience the highest health care costs near their end of life. In California, Medicare per enrollee costs in the last six months of life averaged over $46,000 between 2003 and 2007 (compared to roughly $10,000 per member per year for enrollees nationally).[14] Relative to the national average, California tends to have higher rates of care utilization in the last two years of life.[15]

C. Performance and Quality in California's Health Care System

While California spends less per person on health care than the nation as a whole, the State performs as well as or better than the U.S across a number of quality measures. The LGHC Task Force selected thirty-nine indicators to assess California's performance against national benchmarks for six priority areas, as described earlier.[16] For full details, including the actual performance scores, see **Appendix III, Table III.3**. For both the Healthy Beginnings and Living Well priority areas, California scored at least as well as the national average across at least 75 percent of the indicators. Across all of the indicators for Redesigning the Health System and Lowering the Cost of Care, California scored higher than the national benchmark. However, the State scored lower compared to national benchmarks on all of the measured indicators for the End of Life category.

A review of Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures from the National Committee for Quality Assurance (NCQA) suggests that, where performance data are available for comparison, California's managed care organizations (MCOs) generally perform at least as well as national MCOs. Eighteen measures from the "Effectiveness of Care" category are selected and compared to California's quality performance for MCOs in three payer types: commercial health management organization (HMO), Medicare Advantage, and Medicaid

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managed care. For full details including the actual performance scores, see **Appendix III, Table III.4**. Across the three payer types, California outperformed the nation on at least 69 percent of indicators. California's commercial HMOs had the highest score of the three payer types, with better performance than commercial HMOs nationwide on 94 percent of indicators, followed by Medicare Advantage, and then Medi-Cal.

Data on California health care costs and performance suggest that the State's high managed care penetration rate results in decreased spending relative to the nation while exhibiting similar or superior performance. However, there are also some notable areas for improvement, particularly for the Medicare population, which has lower rates of managed care enrollment than other populations and higher per capita spending than the nation. End of life care represents another opportunity for improvement, given the State's higher spending and lower performance in this area.

D. California's Health Care Market

To better understand the California health care market, it is helpful to review the major purchasers and payers and their respective shares, as well as the breakdown by insurance coverage and type.

In California, state public purchasers account for 32 percent of insured individuals (9.5 million out of 30.0 million) and 25 percent of spending ($41.7 billion out of $166.5 billion). For the commercially insured and Medicare populations, the market is dominated by a handful of payers, while the Medi-Cal market is much less concentrated. Specifically, Kaiser, Anthem Blue Cross, and Blue Shield account for almost 70 percent of the commercial market (with Kaiser alone accounting for over 30 percent). Kaiser accounts for over 45 percent of the Medicare Advantage market, with an additional 30 percent accounted for by Anthem Blue Cross, Blue Shield, Health Net, and United Healthcare. In the Medi-Cal market, Kaiser comprises less than 5 percent, and the three largest payers (Kaiser, Anthem Blue Cross, and Health Net) together comprise less than 35 percent, with the remainder of the market accounted for by other payers.[17]

A major characteristic of California's health care market is the significant managed care penetration – 48 percent of all people are in managed health plans compared to only 23 percent nationally.[18] Among Californians enrolled in Medicare, only 26 percent are enrolled in managed care, while 61 percent of Medi-Cal enrollees are in managed care (**Appendix III, Table III.5**). While California may have high managed care penetration compared to the nation, over half of individuals still participate in FFS systems, suggesting that there is still significant room for moving toward payments that reward value and performance.

As **Appendix III, Table III.5** shows, 21 percent of individuals are uninsured across the State, but this ranges across the regions from 15 percent in the Bay Area/Sacramento to 26 percent in Los Angeles. There is less variation in Medicare coverage across the State; although rates of Medi-Cal and private/other coverage also vary. Regions with higher percentages of uninsured also have higher Medi-Cal coverage rates, likely reflecting lower incomes in these regions.

E. Initiatives and Demonstrations Underway

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The California health care environment offers fertile ground for testing a range of reforms and momentum for scaling them up. There are a large number of federally-supported initiatives underway aimed at improving health care quality, reducing health care costs, or improving health outcomes. The scope of these is quite broad, encompassing a wide range of initiatives spanning Medi-Cal, Medicare, Centers for Disease Control, and the Health Resources and Services Administration. A sampling is listed here, but **Appendix III, Table III.6** provides a more detailed accounting.

- ***The Medi-Cal Coordinated Care Initiative***, which provides integrated medical, behavioral, and long-term care services to Medi-Cal enrollees requiring long-term services and supports;
- ***Medicare Bundled Payments for Care Improvement***, in which organizations enter into payment arrangements that include financial and performance accountability for episodes of care;
- ***Community Transformation Grants,*** which support health and health-care coalitions to implement community-wide chronic disease prevention programs; California counties received more than 20 percent of all CTG funding nationwide;
- ***Multiple private sector initiatives***, including (but not limited to) 17 Health Care Innovation Awards and 350 grants from the Health Resources and Services Administration (HRSA) related to a number of objectives.

The State's innovative and forward thinking approach to Medi-Cal demonstrates an institutional commitment to improving health care access and quality while controlling costs. CMS has granted a number of waivers to Medi-Cal. Most significantly, the State has implemented the Section 1115 Demonstration Waiver, "Bridge to Health Reform," which provides health care coverage for more than 500,000 uninsured individuals through county-based coverage programs as a transition to implementation of the Affordable Care Act. The Bridge to Health Reform also enrolls in Medi-Cal managed care certain seniors and people with disabilities and offers incentives to safety-net hospitals that achieve benchmarks for improving quality of care and patient experience.[19] In addition to this 1115 waiver, California has a number of waivers supporting the provision of home and community-based services (HCBS), including waivers for those with: autism, developmental disabilities, or mental retardation; individuals who are medically fragile and technology dependent; enrollees with HIV/AIDS; individuals ages 65 and older or those ages 21 – 64 with physical disabilities; and enrollees ages 65 and older who would otherwise need nursing facility placement.

Moreover, California's private health care sector is implementing a number of programs aimed at improving health care and constraining costs. For more details about the full range of these initiatives, please see **Appendix III, Table III.6**. The California SHCIP builds upon this extensive activity already underway to leverage and programs for maximize impact.

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III. Proposed Payment and Delivery System Initiatives

This section describes the four payment and delivery system initiatives, each of which corresponds to one or more LGHC goals, builds on California's history of providing coordinated care, and links to existing innovations underway.

A. Maternity Care Initiative

The Maternity Care initiative is designed to address issues of high cost and ongoing quality shortfalls in maternity care, with a focus on deliveries and the significant cost and quality concerns that are related to unnecessary Cesarean sections.

1. Background

Approximately 502,023 babies are born each year in California.[20] Nearly half (46 percent) of these births are paid for by Medi-Cal.[21] Further, deliveries and related expenses, including high-risk births, rank among the top ten high cost episodes for many large employers for both HMO and PPO insurance products.[22] Despite a variety of efforts to bring down the cost of maternity care, particularly by reducing elective Cesarean Sections, progress has been slow.[23]

- Today, the average vaginal delivery (facility costs and professional fees) in California costs $11,500 for commercial payers and $4,590 for Medi-Cal, whereas the average Cesarean delivery costs $18,800 for commercial payers and $7,451 for Medi-Cal.[24]
- Each year in California an estimated 7,000 early elective deliveries, defined as deliveries greater than 36 and less than 39 weeks gestation, had a scheduled cesarean or induction without medical indication.
- Cesarean section deliveries in California rose from 22 to 33 percent between 1998 and 2008 and now total more than 165,000 per year.[25] While the statewide cesarean delivery rate is 33 percent, some outlier hospitals have rates as high as 71.4 percent.[26]
- Moreover, 44 percent of California hospitals do not offer a meaningful Vaginal Birth After Cesarean (VBAC) opportunity (less than 5 percent of attempts) for their Medi-Cal patients despite recommendations from the National Institutes of Health Consensus Development Conference, which determined that a vaginal labor trial for subsequent children was a "reasonable option.[27,28]

In addition to cost and quality concerns, there are notable disparities in deliveries. With respect to Medi-Cal patients: non-Hispanic Black women have disproportionately higher cesarean section rates and higher maternal morbidity and mortality rates; while native born Hispanics have significantly lower rates of VBAC than other groups.[29] Similar racial variation is observed in the University of California, San Francisco[30] and among Kaiser Permanente members in Southern California hospitals.[31] Recent analyses have noted significant variation in these rates among California hospitals indicating that improvement opportunities exist.[32, 33] Further, evidence shows that in hospitals and health care systems adopting initiatives aimed at reducing early elective deliveries, scheduled births, and elective cesareans, such initiatives have shown very promising results.[34,35]

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2. LGHC Goals

Improved Maternity Care relates to the following LGHC goals and indicators.

Healthy Beginnings: Laying the Foundation for a Healthy Life
New metrics will be added that correspond to the three objectives related to early elective deliveries, Cesarean sections, and vaginal births after Cesarean section
Lowering the Cost of Care: Making Coverage Affordable and Aligning Financing to Health Outcomes
Compound Annual Growth Rate (CAGR) by total health expenditures and per capita costs.
Most care is supported by payments that reward value
Transparent information on both the cost and quality of care

3. Current Activities Underway

There is significant activity underway in California to improve maternity care. For example, hundreds of hospitals are participating in the Partnership for Patients, with assistance from six Hospital Engagement Networks (HENs) that help identify and spread best practices in reducing early elective deliveries. This effort is slated to expire at the end of 2013. In addition, the California Maternal Quality Care Collaborative (CMQCC) has engaged a wide range of stakeholders across the State to improve health outcomes of mothers and newborns through best practices. Currently, nine month-old data for all California births is reported to CMQCC's reporting initiative and 41 out of 252 maternity hospitals, representing 45 percent of all California births, report more detailed data to CMQCC every month and participate in a variety of quality improvement projects. Hospital systems, notably Dignity Health, Sutter Health, and Kaiser-Permanente, are also working with their member hospitals to improve performance. Sutter Health demonstrated a remarkable 83 percent reduction in elective early deliveries in a one-year period within a group of 25 participating hospitals.[36] Similarly, Dignity Health reduced elective early deliveries from 7 percent to 1 percent across their entire health system.[37]

With respect to payment reform, the Pacific Business Group on Health (PBGH) is working to develop a blended facility payment for maternity care, alongside a physician performance program, which is being piloted with Aetna, Cigna, and Blue Shield of California within four hospitals and medical groups in 2014. This work builds off of a similar effort in Washington State's Medicaid program that reduced payments for uncomplicated Cesarean sections to that of vaginal births, resulting in one of the lowest Cesarean section rates in the country. In addition, IHA is including some maternity metrics into its Pay-for-Performance program in 2014, which currently applies to physician organizations.

4. Objectives and Targets

Expert stakeholders and the State team identified three objectives (listed below) for improving Maternity Care performance through a coordinated multi-payer effort.

- ***Reduce rates of early elective deliveries by a further 50 percent, to less than 3 percent by the end of 2017***. According to experts, as a result of significant focus on this area in recent years, 40-50 percent of hospitals are close to the target. These activities provide an excellent platform for accelerating the spread of these and other delivery-related quality improvement efforts with support from the SHCIP.

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- ***Reduce Cesarean section rates overall by 10 percent, from 32.8 percent to 30 percent by the end of 2017***. The quality improvement focus will be on reducing cesarean sections for low-risk, first birth deliveries, by far the largest portion of primary cesarean births, with a targeted reduction from a statewide average of 27.7 percent to 23.9 percent (the Healthy People 2020 target for this measure).
- Repeat Cesareans will be targeted by incentivizing an increase of vaginal births after delivery (VBACs) from 9 percent to 11 percent by the end of 2017, where safe and appropriate.

5. Action Steps

The SHCIP will build upon/complement the aforementioned efforts through the following action steps:

a) State purchasers and select large employers and health plans will require hospitals, from which they purchase maternity care, to report appropriate and timely data to the California Maternal Quality Care Collaborative (CMQCC) in order to publicly report maternity outcomes and drive quality improvement activities. These data will be made available on the Office of the Patient Advocate website. More importantly, detailed and timely reporting back to hospitals and physicians will be used for performance improvement purposes.

b) State purchasers and select large employers and health plans will incent hospitals to establish "hard-stop" policies to prevent early elective deliveries, requiring a provider looking to schedule an early elective delivery to seek internal second opinions from a designated department leader.

c) State purchasers and select large employers and health plans will implement a Value-Based Purchasing program with a significant portion of the hospital payments for maternity care tied to these three quality measures. A blended payment approach (such as a single payment for "birth" rather than separate payment levels for vaginal and cesarean births) will be developed to serve as a back-stop approach should progress towards the goals be limited. These payment approaches will be built upon the efforts noted previously (e.g., PBGH, Washington State) *and* identify maternity metrics to include in IHA's value-based pay-for-performance (P4P) program. IHA will expand the P4P program to include hospitals and develop a value-based purchasing incentive program (with an upside and downside) for non-managed care providers for delivery-related metrics.

d) The State team will develop a process for determining outlier hospitals and oversee an annual review of them. This will include a performance improvement plan for which they will be assisted by the State maternal quality improvement team led by CMQCC.

6. Use of Testing Funds

If awarded, CalSIM testing funds will support: (1) universal enrollment in the CMQCC Maternal Data Center; (2) the widespread implementation of a value-based payment program to include all payers, including Medi-Cal, and that will cover hospital and, through the hospital, provider payments; (3) development of a blended payment rate, including providing Medi-Cal-specific technical assistance as needed (Medi-Cal reimbursement currently includes an additional payment to those facilities that have relatively higher risk patients); and (4)

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implementation of a statewide maternity performance improvement team to audit outlier facilities and assist hospitals and providers in meeting the quality targets.

B. Health Homes for Complex Patients Initiative

The health homes initiative will implement and spread care models, which include coordinated, team-based care, in order to improve the quality of care and outcomes for medically complex patients across both public and private purchasers.

1. Background

As previously noted, across all California payers, five percent of the population accounts for over half of health care expenditures in a typical year, with people who suffer from multiple chronic conditions or who are at the end of life being major contributing factors.[38] Studies show that coordinating care through health homes improves the patient experience and health outcomes while controlling costs.[39,40] Expert stakeholders and the State team focused on complex patients, in particular, to meet the federal requirement to demonstrate a return on investment within a three-year period.

According to a 2013 report from the California Department of Public Health, about 38 percent of Californians have one or more chronic conditions, and almost 25 percent experience limitations in their daily activities due to chronic conditions.[41] Furthermore, a survey shows that among US adults with chronic conditions, in 2008, 19 percent found it difficult to contact their providers during practice hours, while 60 percent were unable to get the advice they needed when calling a help line. After hours posed even greater access issues for this population, and 60 percent found it somewhat or very difficult to access the care they need without going to the emergency room. Additionally, of those adults with chronic conditions seeking an appointment with a specialist, 22 percent faced wait times of a month or more.[42]

While per capita Medi-Cal spending is about 33 percent lower than national per capita Medicaid spending, Medi-Cal spending is still characterized by skewed expenditures. In 2010, The Lewin Group conducted an extensive analysis of the most expensive utilizers in FFS Medi-Cal for the California Healthcare Foundation.[43] **Appendix III, Table III.2** shows study findings, illustrating that 7 percent of enrollees generate 76 percent of expenditures. Among individuals with expenditures more than $10,000 per year, two-thirds have two or more chronic conditions; many have both mental and physical health needs. Reflecting the nature of chronic disease, enrollees that are high cost in one year are often among the most expensive in subsequent years. Among beneficiaries with more than $10,000 in expenditures (2006), 59 percent remained in Medi-Cal two years longer and continued to exceed $10,000 in annual expenditures. A higher percentage of Medicare beneficiaries have multiple chronic conditions than other payers; many high-cost enrollees are also jointly eligible for Medicare and Medicaid – individuals enrolled in both programs comprise 15 percent of all Medi-Cal enrollees but 46 percent of enrollees with $10,000 or more in spending per year.[44]

The cost burden of chronic illness – estimated to be about 75 percent of total health spending nationally– will continue to grow as the prevalence of chronic diseases increases. These factors, along with a growing shortage of primary care clinicians, make a compelling case for widespread dissemination of Health Homes for Complex Patients.[45] Although 48 percent of

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California's insured population is enrolled in HMO plans, not all of these individuals receive coordinated care, referral to community and social support services, and other features that are characteristic of health homes (see definition below).

2. LGHC Goals

The Health Homes for Complex Patients initiative has the potential to affect the following LGHC goals and indicators.

Living Well: Preventing and Managing Chronic Disease
Overall health status reported to be good, very good or excellent
Percent of adults diagnosed with hypertension who have controlled high blood pressure
Percent of adults diagnosed with high cholesterol who are managing the condition
Prevalence of diagnosed diabetes, per 100 adult
Effectively treating depression
End of Life: Maintaining Dignity and Independence
Terminal hospital stays that include intensive care unit days
Redesigning the Health System: Efficient, Safe, and Patient-Centered Care
Percent of patients receiving care in a timely manner
Percent of patients whose doctor's office helps coordinate their care with other providers or services
Preventable Hospitalizations, per 100,000 population
Linguistic and cultural engagement
Lowering the Cost of Care: Making Coverage Affordable and Aligning Financing to Health Outcomes
Compound Annual Growth Rate (CAGR) by total health expenditures and per capita costs. For comparison, CAGR by Gross State Product is included
Most care is supported by payments that reward value
Transparent information on both the cost and quality of care

3. Current Activities Underway

There are several significant efforts underway in California to create and spread health homes within safety net clinics, physician organizations, and hospitals. There are 241 physicians working on 32 NCQA-rated Patient Centered Medical Homes across the State. Almost 80 percent of NCQA-rated PCMHs exist in Orange, Riverside, and Tulare counties. Other notable activities in the State include a $19 million effort funded in 2012 for three years by the Center for Medicare and Medicaid Innovation for PBGH to implement an Intensive Outpatient Care Program (i.e., health homes for complex patients). This initiative targets 20,000 Medicare patients within 20 physician medical groups, primarily in California. To date roughly half are in place.

The California Primary Care Association is supporting its member clinics to implement the patient-centered health home (PCHH). To date, approximately 10 percent of 900 clinic sites have implemented the PCHH.[46] In partnership with The California Endowment, the Center for Care Innovations has funded eight, two-year collaborative projects among safety net institutions to build patient-centered, integrated systems of care and explore options for payment reform to incent and sustain health home implementation.

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There are examples of other innovative efforts, between managed care plans and providers to establish health homes, such as the initiative in which Partnership Health Plan and Redwood Community Health are testing two care manager models – one where the care manager is hired by the health plan and embedded into a health center, and the other where the care manager is hired directly by the health center. As part of California's participation in the Delivery System Reform Incentive Payments (DSRIP) program, several counties, hospitals, and health systems have developed health home initiatives. As one example, Contra Costa Regional Medical Center and Health Centers is establishing a primary care medical home, where patients have a health care team that is tailored to the patient's health care needs, coordinates the patient's care, and proactively provides preventive, primary, routine and chronic care. The program aims to achieve improved health among participants, reduced reliance on emergency department care, fewer avoidable hospital stays, and increased patient satisfaction. A start-up organization, the California Advanced Primary Care Institute is beginning to create stepwise regional/ community-based practice coaching to accelerate patient centered, modernized, team-based care. The Institute is partnering with the UC San Francisco Center for Excellence in Primary Care, the California Quality Collaborative, and LA Net to build a curriculum designed to enhance local community capacity in quality improvement and practice coaching.

At the State level, California's Bridge to Reform Section 1115 Medicaid waiver expands access to county-based Low Income Health Programs for low-income adults (aged 19-64) who do not qualify for Medi-Cal. Up to 500,000 low-income uninsured residents are enrolled in a medical home under this waiver. Finally, next spring of 2014, California's Department of Health Care Services (DHCS) will launch a major three-year project to promote coordinated health care delivery. Through Cal MediConnect, up to 456,000 Medi-Cal beneficiaries (seniors and people with disabilities) in eight selected counties who also receive Medicare benefits (dual-eligibles) will receive coordinated medical, behavioral health, long-term institutional, and home-and community-based services through a single organized delivery system. The Cal MediConnect program aims to improve care coordination and drive high quality care that helps people stay healthy and in their homes for as long as possible. In addition, shifting services out of institutional settings and into the home and community will help create a person-centered health care system that is also sustainable.

4. Objectives and Targets

Expert stakeholders and the State team identified one main objective for this initiative, which is to spread health homes for complex patients in California by the end of 2017. Because baseline information on current health homes in place or in progress does not exist, the target for this initiative will be set at a later date. Presently, there are varying definitions of what constitutes a health home for complex patients, a clear definition will be developed in the first months of the testing phase, should CalSIM testing be funded. In general, key functions of a health home include: population risk stratification, comprehensive care management, care coordination and health promotion, team-based care that includes frontline workers, like community health workers, comprehensive transition care between care settings, referral to community and social support services, individual and family support (including authorized representatives), and electronic capture and movement of critical information. California will also consider standards related to staff or contracted expertise on palliative care, to support the Palliative Care initiative described in the next section. Upfront risk stratification to identify the

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highest risk patients will also prove helpful in identifying potential candidates for palliative care within a health home.

5. Action Steps

The Health Homes for Complex Patients initiative will spread health homes through the following steps.

a) State purchasers and select large employers, providers, and health plans will jointly define required functionality needed for a health home for complex patients that would satisfy market needs, certification requirements, and criteria set forth in section 2703 of the Affordable Care Act for Medicaid programs.[47] Because such a significant percentage of Medicare beneficiaries have complex medical needs, it will be critical to engage CMS in these discussions in order to promote adoption across all payers.

b) State purchasers and select large employers will require health plans to create and demonstrate innovative (non fee-for-service) incentives for providers to achieve specified functionality for a health home for complex patients. Incentives may range from having a health plan assume particular functions, such as population risk stratification, or hiring community health workers to work with a provider organization(s), to alternative payments, such as shared savings based on performance.

c) State purchasers and select large employers and health plans will ask providers to demonstrate how they are incorporating frontline and allied health professionals into their teams. Because these types of professionals tend to be more reflective of the communities in which they serve, cultural engagement with patients will be enhanced.

6. Use of Testing Funds

The Health Homes for Complex Patients Initiative would consume a significant share of California's federal testing funds, given the scope of the initiative and geography to be covered. Funds would be used for the following activities:

- Create a common definition of health homes for complex patients;
- Identify the most promising locations for implementation, with special attention to rural areas and areas where care is currently reimbursed by fee-for-service and where payer and provider interest is high;
- Provide needed practice transformation training and workforce development;
- Support the Department of Health Care Services (DHCS) to develop and submit a Medicaid State Plan Amendment (SPA) to qualify for eight quarters of 90 percent federal funds for this initiative;
- Support a full-time staff person dedicated to advancing health homes in the Medi-Cal division of DHCS; and
- Encourage, cross-fertilize, and monitor payment reform innovations that reward performance and performance metrics.

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C. Palliative Care Initiative

The Palliative Care initiative is designed to better meet patient preferences for individuals facing advanced illness with significant risk of death in the next year. As adopted by the National Quality Forum, palliative care means patient and family centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social and spiritual needs and facilitating patient autonomy, access to information and choice. Advanced illness is defined as persons with consistent and serious complications from chronic or terminal disease. Together with the Health Homes for Complex Patients Initiative, this effort aims to identify patients who may benefit from and desire palliative care services and offer them comprehensive end of life benefits in hospitals or community settings by people who are trained in this area.

1. Background

As is true nationally, seniors comprise a growing proportion of California's population. Although death can occur at any age, 73 percent of Californians die after age 65.[48] A statewide survey reveals that only 44 percent of Californians felt that their loved one's wishes were completely followed at the end of their life. Although 70 percent of Californians would prefer to die at home, 42 percent of deaths occur in the hospital.[49] Moreover, the majority of Californians are interested in speaking with their doctor about palliative and hospice care.[50] California hospice utilization lags significantly behind the national average (16.8 versus 21 days of hospice in the last six months of life) and there is also significant geographic variation within the State.[51,52]

There is also wide geographic variation in hospitalizations during the end of life (measured by patient deaths associated with ICU admission). California statewide rates for such hospitalizations within the ICU, as opposed to dying at home or in hospice care, are higher than national rates.[53] A number of initiatives have led to significant provision of palliative services among California's public hospitals (63 percent); however, private entities have not followed in a similar fashion (32 percent currently have hospice services available). According to an estimate by the Berkeley Forum, only 20 percent of potentially appropriate patients have access to community-based palliative care services.[54,55]

This mismatch of patient preferences and care delivery also means that health care costs towards the end of life are significantly higher than they need to be. As of 2010 Medicare FFS hospice utilization (41.3 percent in California) falls below the 50th percentile of states nationally (45.9 percent); moreover, Medicare reimbursements per decedent ($46,686 in California) are well above the 90th percentile of states ($43,728).[56]

There are three key reasons for the misalignment of patient preferences with care received toward the end of life: (1) a lack of advanced care planning, including determining and documenting individual goals and wishes for specific treatments based on medical conditions and personal preferences; (2) a shortage of adequately trained providers and models of care that support palliative care. In California, with a population of 38 million, there are only 1,045 physicians who are board certified in Hospice and Palliative Medicine and 878 nurses (less than .01 percent of the nursing workforce) who are certified by the National Board for Certification of Hospice and Palliative Nurses, according to the National Board as of 2012; and (3) perverse

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financial and benefit incentives, which exacerbate the misalignment.[57,58] The nature of reimbursement of oncology drugs, for example, influences the decision of which chemotherapy to use for cancer patients.[59] Further, palliative care and hospice benefit offerings typically force patients to make a difficult decision to relinquish all curative care. With this backdrop, palliative care is ripe for improvement in California.

2. LGHC Goals

Improving Palliative Care relates to the following LGHC indicators, in particular those under the third goal area, End of Life.

End of Life: Maintaining Dignity and Independence
Terminal hospital stays that include intensive care unit days
Percent of California hospitals providing in-patient palliative care
Hospice enrollment rate
Advance Care Planning
Redesigning the Health System: Efficient, Safe, and Patient-Centered Care
Percent of patients whose doctor's office helps coordinate their care with other providers or services
Preventable Hospitalizations, per 100,000 population
30-day All-Cause Unplanned Readmission Rate (Unadjusted)
Linguistic and cultural engagement
Lowering the Cost of Care: Making Coverage Affordable and Aligning Financing to Health Outcomes
Compound Annual Growth Rate (CAGR) by total health expenditures and per capita costs. For comparison, CAGR by Gross State Product is included
Most care is supported by payments that reward value

3. Current Activities Underway

There are a number of noteworthy efforts underway to improve care for patients near the end of life. To engage providers and patients in advance care planning, the Coalition for Compassionate Care of California (CCCC) provides guides to Advance Care Planning and the Physician Order for Life-Sustaining Treatment (POLST) form as well as training for healthcare providers on the importance of having a meaningful conversation with their patients surrounding POLST. The CCCC is planning a large-scale effort to promote the POLST and develop electronic registry systems in partnership with private payers and providers.

The Palliative Care Action Community, convened by the California HealthCare Foundation, strives to advance the availability of community-based palliative care in California.[60] Across California, there are 525 licensed hospice agencies that deliver services through hospital outpatient services, and community-based programming operated by home care agencies.[61]

To begin to address the high need for training, the California State University of San Marcos (CSU San Marcos) established an Institute for Palliative Care. The Institute offers online/highly replicable training programs to educate current and future professionals. The Institute's educational model features a nurse practitioner palliative care fellowship, integration of palliative care into nursing curriculum, community physician education, and certificate

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programs in palliative care for social workers and chaplains. CSU San Marcos also serves to educate community members on caring for loved ones with serious illness and on bereavement.

Several health plans/hospital systems in the State are working to deliver new models of care for people near the end of life. For example, Sharp HealthCare in San Diego has a *Transitions* program that serves as "pre-hospice," providing in-home services for patients with cancer, congestive heart failure, cirrhosis, chronic obstructive pulmonary disease, and dementia.[62] They report saving an average of $27,000 per patient. Sutter Health Advanced Illness Management Program (AIM), a nurse-led care management, palliative care, and advance care planning program, has received a Health Care Innovation Award from the Centers for Medicare and Medicaid Innovation for a three-year roll out across the entire system. Internal analyses of the Sutter program show more than 50 percent reduction in hospitalizations at 90 days post-enrollment, an average decrease of one or more days for hospitals, and a 75 percent reduction in ICU days.[63]

With respect to the third problem area, perverse financial and benefit incentives, United Healthcare has been testing a chemotherapy bundled payment with five oncology practices since 2010 that has shown to substantially reduce variation between practices. Another approach to redesigning oncology care is the clinical pathways approach that requires oncologists to treat specific clinical conditions with predefined chemotherapy regimens typically selected by a body of physicians. A 2010 study of clinical pathways for lung cancer reported a 37 percent reduction in chemotherapy costs and a 39 percent reduction in non-chemotherapy medications for practices following a protocol developed by US Oncology.[64] In April 2013, The California HealthCare Foundation published an issue brief on the range of palliative care and hospice benefits and services in California and plans and major stakeholders' position on the coverage of concurrent care.[65] In fall 2013, the California HealthCare Foundation will be convening the major insurers in the State to discuss this topic further.

4. Objectives and Targets

The two objectives for the SHCIP are:

- Incorporate palliative care capacity within Health Homes for Complex Patients
- Identify and adopt new benefit and payment approaches to better meet patient preferences for palliative and hospice care.

5. Action Steps

To further the development of palliative care in California, the following elements are included in the SHCIP.

a) Health Homes for Complex Patients Initiative will incorporate palliative care services. Because the Initiative on Health Homes focusing on Complex Patients will focus on individuals with multiple chronic conditions, it is likely that some will be in need of palliative, pre-hospice, or hospice care; this will be particularly true for health homes serving beneficiaries enrolled in Cal MediConnect. Therefore, participating organizations in the Health Homes for Complex Patients will be required to develop protocols for identifying such individuals and for ensuring access to such care. Training of key personnel will also likely be needed; these activities may

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take place at the provider level or by a managed care plan, depending on the particular configuration and relationships of the health home.

b) In partnership with the California HealthCare Foundation, the Integrated Healthcare Association, and other experts, the State team will review and adopt innovative benefit design and payment mechanisms as they are developed. As mentioned above, in Fall 2013 the California HealthCare Foundation is convening major insurers in the State to discuss a better benefit model for palliative care, including opportunities to redesign oncology reimbursement. In conjunction with the SHCIP goal of moving away from a fee-for-service based system, the Integrated Healthcare Association will work to develop meaningful pay for performance measures around palliative care. As shown in **Table I.2**, Medicare and dual-eligible beneficiaries constitute key target populations of this initiative. Therefore, it will be critical to include the Centers for Medicare and Medicaid Services in the development of these models.

c) The State will support training of the current workforce regarding palliative care services. As described in the Workforce Building Block more fully below, training is critical to the spread of palliative care; therefore, the focus of the SHCIP's training activities is on the current workforce. As the centerpiece of the SHCIP, the Health Homes for Complex Patients will receive priority to ensure that there is capacity within the health home to offer trained expertise on palliative care.

d) The State of California will Pursue a Medicare waiver. California would like to allow curative and palliative care to be provided simultaneously through Medicare and to extend the hospice benefit to within 12 months of anticipated death, in line with current California law for managed care organizations. The State would like to take advantage of Section 3140 of the Affordable Care Act, "Medicare Hospice Concurrent Care Demonstration Program," that would allow patients eligible for hospice care to receive all Medicare services during the same period of time in which they receive hospice care. California has been successful in obtaining a Medi-Cal waiver to allow concurrent care for children; in 2009 Medi-Cal launched the Partners for Children program which provides family-centered pediatric palliative care for medically fragile and technology-dependent individuals age 0 – 20 in participating counties.[66]

6. *Use of Testing Funds*

CalSIM testing funds would be used to ensure that palliative care candidate patient identification is included in the Health Homes for Complex Patients initiative. Monies will also support frontline worker and provider trainings, an application for the Medicare waiver application, and technical expertise and convening of experts to identify new benefit and payment models that can be adopted by state purchasers, select large employers, and ideally, Medicare.

D. Accountable Care Community Pilots Initiative

The Accountable Care Community Initiative will support the development of two or three Accountable Care Community (ACC) pilots that will model how population health can be advanced through collaborative, multi-institutional efforts that promote a shared responsibility for the health of the community. Pilots will focus, in particular on populations and/or conditions with demonstrated health disparities and include a Wellness Trust, serving as a vehicle to pool and leverage funding from a variety of sources for long-term sustainability.

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1. Background

Meeting the Triple Aim of better health, better care, and lower costs requires addressing underlying social, economic, and behavioral determinants that significantly impact individual and population health.[67] Historically, however, population and public health efforts, which involve non-health care related sectors, have had little interaction with the health care delivery system. People with chronic conditions, such as diabetes, cardiovascular disease, and asthma who could benefit from community-based prevention, social services, and other supports often are unaware of these resources.

A relatively recent innovation to improve population health and health care is the creation of an ACC. An ACC establishes a collaborative, multi-institutional approach that brings together the health care sector, government, non-profit and private sectors, including community organizations, emphasizing shared responsibility for the health of the community. The purpose of an ACC is to identify priorities and action steps to achieve the Triple Aim. While individual health care providers and systems may seek to achieve the Triple Aim for their specific *members*, a different type of structure is needed to advance these goals on behalf of the entire community, especially for those facing significant health disparities as a result of the community conditions they live in. The ACC would enable the community and its various health and health care stakeholders to build a common understanding of the problems, create a shared vision, and develop interventions to improve the community's health.

Elements of an Accountable Care Community include:

- Identification and agreement of goals and metrics of success, including an "Impact Equation" or other mechanism to assess the impact of prevention-oriented interventions and quantify savings;[68]
- Explicit attention to addressing health disparities;
- Agreement to share relevant data for tracking and, ultimately, accountability purposes;
- A "backbone" or host entity to provide leadership and administrative support;[69]
- A governance structure that provides for joint decision-making and prioritization of interventions; and
- A financing mechanism to pool resources from participating partners, capture savings resulting from agreed-upon interventions, and reinvest such savings back into the community (hereinafter referred to as a Wellness Trust).

2. LGHC Goals

The Accountable Care Communities pilots relate to the following LGHC indicators. Because the pilots may initially choose to focus on particular conditions, such as asthma, diabetes, or cardiovascular disease, or particular populations, such as children, indicators across several goal areas are included. Each ACC pilot will identify the indicators that relate most directly to the population(s), condition(s) and intervention(s) that they decide to prioritize locally. That said, because the ACCs are limited in scope, it is unlikely they will impact indicators at an overall state level.

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Healthy Beginnings: Laying the Foundation for a Healthy Life
Proportion of children and adolescents who are obese or overweight
Emergency department visits, 0-17 years due to asthma per 10,000
Proportion of adolescents who meet physical activity guidelines for aerobic physical activity
Adolescents who drank 2 or more glasses of soda or other sugary drink yesterday
Adolescents who have consumed fruits and vegetables five or more times per day
Proportion of children and adolescents who are obese or overweight
Proportion of adolescents who smoked cigarettes in the past 30 days
Living Well: Preventing and Managing Chronic Disease
Overall health status reported to be good, very good or excellent
Percent of adults diagnosed with hypertension who have controlled high blood pressure
Percent of adults diagnosed with high cholesterol who are managing the condition
Proportion of adults who are obese
Prevalence of diagnosed diabetes, per 100 adult
Proportion of adults who meet physical activity guidelines for aerobic physical activity
Adults who drank 2 or more sweetened beverages per day
Adults who have consumed fruits and vegetables five or more times per day
Proportion of adults who are current smokers
Redesigning the Health System: Efficient, Safe, and Patient-Centered Care
Percent of patients whose doctor's office helps coordinate their care with other providers or services
Creating Healthy Communities: Enabling Healthy Living
Number of healthy food outlets as measured by Retail Food Environment Index
Annual number of walk trips per capita
Percentage of children walk/bike/skate to school

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3. *Current Activities Underway*

An ACC-type reform has not been implemented in California. However, it will be modeled after an initiative implemented in Akron, Ohio, whose director just received a White House Champions for Change award, [70,71] as well as states and localities that have established Wellness Trusts, such as Massachusetts and North Carolina. Similar models and ideas are emerging rapidly in Oregon, Minnesota as well as through the literature.[72] The Akron ACC focused on reducing diabetes as its first priority. It established a shared savings financing system such that savings from improving the health of a diabetic population would be shared among the providers and the ACC; the ACC, in turn, would reinvest its savings in community prevention initiatives as well as use them to support its "backbone" operations. Within 18 months, there have been notable results including a 10 percent reduction in the average cost of care for participants – and quantified savings to the health system.

In California, several cities and counties are implementing elements of similar community-wide efforts but without the formal structure proposed in this initiative that would enable sustainability and spread. For example, in 2010, San Diego County initiated a ten-year roadmap, known as, "Live Well, San Diego!" to comprehensively improve the health of the population and enhance health, safety, and economic vitality for the entire region. The plan brings together the health care delivery systems from across the entire region, comprising about 90 percent of the private market, as well as the Navy, Veterans' Administration, and county Health and

Human Services agency, to promote "co-opetition." The plan also involves other sectors, such as businesses, faith-based organizations, and community and social service providers. On the health care side, several San Diego medical groups participate in the state-assisted Right Care Initiative. The Right Care Initiative possesses a track record of success in improving outcomes for managed care enrollees with cardiovascular disease and diabetes. As San Diego has been the recipient of many federal and private grants to spur innovation, it has many of the building blocks described above already in place.

Similarly, the Beach Cities Health District (Hermosa, Redondo and Manhattan Beach) has been spearheading a community-wide effort to improve the health and well-being of residents, focusing on reducing smoking and improving exercise and healthy eating through environmental and policy change. Through a partnership with the Blue Zones Project, they have seen a 14 percent reduction in obesity resulting in an estimated $9.3 million in health care savings.

With regard to Community Health Workers, public health departments in 12 counties that received Community Transformation Grants from the federal government – so-called CA4Health counties – are already collaborating with healthcare professionals, clinics, hospitals, other public agencies, and community-based organizations to improve connections between the health care delivery system and resources within the community that support healthier behaviors. Community Health Workers, as frontline public health workers who are trusted members of their community, serve as liaisons to services, lead Chronic Disease Self-Management Program workshops, and are being trained to facilitate access to other community services that support and enhance health.

4. Objectives and Targets

Because this is a pilot project, the primary objectives are:

- Develop replicable programs or elements of programs, including infrastructure, partnerships between different sectors, payment reforms, such as shared savings
- Develop replicable models for the Wellness Trust.

Because the number of ACCs will be limited, they will not likely contribute to statewide improvements in the indicators identified above. However, they will be responsible for identifying specific targets associated with select indicators, depending on the intervention.

5. Action Steps

There are several steps to implementing ACCs in California. Unlike several of the other initiatives, the process is fairly linear with a series of sequential steps instead of multiple co-occurring activities.

a) The State will select communities to pilot ACCs. The first step will be selection of communities to receive SHCIP grant money for establishment of the ACC and the Wellness Trust. Given the short duration of the grant, California plans for some "pre due diligence" before the grant is awarded. During this period, California Health and Human Services Agency (CHHS) or its designee will identify communities interested in becoming ACCs, conduct preliminary screening, and generate a pool of finalists. To increase the likelihood of achieving

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results within the short grant period, criteria for preliminary screening include readiness, capacity, and level of existing collaboration. Potential criteria may also include: a geographically-defined community and population that includes communities bearing a disproportionate burden of chronic disease; interest in participating among health care providers and payers; agreement to share information and data as allowed under law; presence of integrated or coordinated systems of care (PCMHs, ACOs, etc.); health information technology (HIT) systems that support integration of population health and clinical data; active engagement and capacity by the public health department with a commitment to a "health in all policies" approach; and identification of a likely entity to serve as the "backbone organization" of the ACC and host of the Wellness Trust.

b) ACC pilots will create Wellness Trusts and identify sustainable financing mechanisms. While communities will receive up-front funding for ACC and Wellness Trust establishment, they must outline a plan for securing ongoing resources to sustain the necessary infrastructure. Sources of funding may include (but are not limited to): philanthropy, hospital community benefits, health plans, community reinvestment, governmental grants or other grants, contributions from partners, as well as savings from more efficient utilization of health care resources. Communities must demonstrate that their shared savings payment reforms include distribution of savings among both participating providers and with the ACC to sustain activities and reinvest in initiatives.

c) Designated communities will develop the infrastructure and implement programs to address the agreed upon priority condition. During the three-year grant period, each participating community will create a shared vision for a transformed health system. Although the long-term vision of ACCs is to improve population health broadly, initially, the ACC will focus on one of three chronic conditions that have documented health disparities, well-established evidence-based interventions, potential to demonstrate a return-on-investment within three years, and in which the environment is a significant contributor to poor health outcomes: asthma (especially childhood asthma), diabetes, and cardiovascular disease. Each participating community will select one of these three conditions, develop a set of goals and strategies to address the condition, and identify a limited number of community population health outcomes to assess progress and performance. Communities should select appropriate indicators from LGHC Task Force[73] or from the Healthy Community Indicators and Data Project.[74] Communities will develop an impact equation and initiate payment reform(s) based on the equation (shared savings, pay-for-performance, etc.).

d) ACCs will utilize, to the extent practical, community health workers or other frontline workers as bridges between the health care system, community organizations, social service providers, and individuals who are the focus of the intervention. While ACCs may initially pay for community health workers, they should identify costs and benefits of workers during the initial phase to develop sustainable financing mechanisms. At its core, the ACC is about collaboration, and initial communities will be selected based on existing collaboration. Up front funding will incent further collaboration, while participating sites develop mechanisms for supporting ongoing activities.

6. Use of Testing Funds

CalSIM funds would support State activities regarding the selection of sites, implementation, and oversight. CalSIM funds would also be used as start-up funding to develop the

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infrastructure, incent further collaboration among partners, and seed the Wellness Trust to leverage ongoing resources for ongoing sustainability.

IV. Building Blocks to Enhance Initiatives and Promote System-wide Accountability

In order to advance the four initiatives over the short and longer-term transformation process, the SHCIP includes six building blocks. The first three--Workforce, Health Information Technology and Exchange, and Enabling Authorities--directly support the initiatives and will help enable their success.

The second three building blocks—the All-Payer Claims Database (APCD), Public Reporting, and the Payment Reform Innovation Incubator —are designed to enhance system-wide efforts to promote competition and accountability in order to bend the cost curve over the long term. California is ahead of many states in measuring total costs of care and performance at both the health plan and delivery system levels. California's Office of the Patient Advocate, for example, publicizes quality and patient experience information on managed care plans and medical groups. The Office of Statewide Health Planning and Development produces reports on outcomes for hospitals. The nonprofit Integrated Healthcare Association possesses over a decade of experience in convening stakeholders to develop publicly reported efficiency and clinical quality measures. Yet despite progress to date, information on total costs of care, comprehensive performance, including quality information and patient experience, across *all* health plans and providers, and total population health in California is not consistent and readily available. These building blocks aim to build on current assets and accelerate California's path to make more robust administrative and clinical information available and accessible to the marketplace, consumers, and policymakers.

A. Workforce Building Block

Successful transformation of the health care delivery system depends on ensuring adequate capacity, training, and cultural engagement of a wide range of health care professionals. Each of the key initiatives will require one or more of these workforce-related components to be successful.

1. Background

California currently faces a shortage of health professionals able to meet the needs of the State's diverse population. The health delivery system will be further strained as up to 5.9 million newly insured persons seek care starting in 2014.[75] The expected increase in health workforce demand occurs simultaneously with major supply challenges. Only 16 of 58 counties meet the nationally recommended ratio of primary care physicians per capita; eight counties have fewer than half of the recommended number.[76] Less than 25 percent of medical graduates go into primary care, leading to a reliance on Foreign Medical Graduates who comprise a significant share of the State's primary care physician workforce.[77] One bright spot is that California just began enrollment in the first new public medical school in nearly 40 years. Based at the University of California in Riverside, an area of very high need, this new medical school will focus on primary care and community health and seek students who intend to stay in the Riverside and San Bernardino area and are from populations underrepresented in medicine.

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On the specialty care front, some areas of the State exceed the recommended supply by a significant degree, while other areas, especially the Central Valley and the Riverside-San Bernardino area experience shortages. Similarly, there is a significant shortage of mental health professionals with more than 10 percent of the population living in areas designated by OSHPD as a mental health professional shortage area.[78]

The State also faces an imbalance in the racial/ethnic composition of the health workforce, which does not reflect the population at large. For example, Latinos comprise 38 percent of the California population, but only 5 percent of physicians and 8 percent of nurses. The lack of representative physicians is a contributor to persistent disparities in health access, quality, and outcomes.

There are several State plans for addressing health workforce issues broadly, including a March 2013 report by the California Workforce Investment Board Health Workforce Development Council and OSHPD's recently released strategic plan regarding health care workforce priorities. The SHCIP workforce action steps outlined in this section are in line with these strategies, providing value-added opportunities to activities underway within the California health care marketplace and by the State. Through targeted enhancements to the existing workforce and the creation of new opportunities for non-traditional workers, this important building block will help ensure the successful implementation of the four initiatives.

2. Objectives and Targets

California has extensive and varied health workforce needs, which will be magnified by the millions of newly insured Californians who will be seeking care. Meeting these needs will require a range of strategies across many disciplines beyond the scope of the SHCIP. Therefore, the SHCIP's workforce building block is focused on activities that will support the four initiatives and better enable their success. The objectives of this building block are, in particular, to:

- Enhance training opportunities for key health workforce personnel associated with the four initiatives, and
- Expand and integrate the use of frontline and lower cost health workers, such as community health workers.

3. Action Steps

a) Three initiatives—Health Homes for Complex Patients, Palliative Care, and Accountable Care Communities –will incorporate frontline workers in order to expand primary care/non-medical service capacity and enhance cultural engagement. Allied professionals and frontline workers, including medical assistants, case managers, community health workers, social workers, peer support specialists, and promoters, play critical roles in team–based primary care and represent a key strategy for both increasing overall capacity of the health workforce and enhancing its cultural engagement.

Health homes for complex patients emphasize team-based primary care; a critical aspect is for payers to create innovative payment incentives that stimulate demand to employ and deploy these types of workers in support of the primary care physician and care of the patient. Many of

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the needed services for complex patients are non-medical in nature and frontline workers are best suited to address these needs.[79] Further, frontline workers often are drawn from the communities they serve, allowing for enhanced cultural engagement with respect to patient services.[80] The Health Homes for Complex Patients initiative also requests payers to create financial incentives for providers to employ cost-effective technologies, such as telehealth, which will help alleviate the uneven distribution of specialty care.

Similarly, in the Palliative Care context, frontline workers may serve as an important community-based extension of the health care system. Community health workers' understanding of both the health system and the culture/language of their patients uniquely equips them for the difficulties associated with end of life care.[81] As members of the community, they can guide patients through difficult end of life decisions - including designating health care proxies, making advance directives, and describing end of life wishes - in a comfortable, familiar setting.[82] As health system insiders, they serve as liaisons between patients and the health system - sharing patients' fears, misperceptions and confusions with providers - to improve the delivery of palliative care. Finally, community health workers can be particularly helpful to minorities who have historically experienced access barriers and may have greater distrust of the health care system.[83]

The Accountable Care Community initiative will include a requirement for pilot communities to incorporate community health workers into their strategy for bridging health and health care needs locally. Frontline workers, such as community health workers, can serve on primary care teams in a variety of ways and settings. The ACC pilot will identify how best to include them, focusing in particular on their ability to help build trust and communication between patients and providers, help patients manage their health and navigate the care system, as well as bridge between the health care system and community and social services. For example community health workers may conduct home assessments and educate families with regard to asthma triggers, including identifying housing issues or other environmental conditions that trigger asthma.

b) OSHPD will leverage its workforce investments to maximize support for health homes and, possibly, Accountable Care Communities in underserved communities. Through its healthcare workforce development division, OSHPD serves as California's primary care office supporting the State's healthcare workforce through pipeline development, training and placement, financial incentives, systems redesign, and research and policy with a focus on underserved and diverse communities. Specifically, OSHPD encourages demographically underrepresented groups to pursue healthcare careers; deploys primary care and mental health practitioners to underserved communities; evaluates new and expanded roles for health professionals and new health delivery alternatives; designates health professional shortage areas; and serves as the State's central repository of health workforce and education data. Also at OSHPD, the Health Professions Education Foundation improves access to healthcare in underserved areas of California by providing scholarships, loan repayments, and programs to health professional students and graduates who are dedicated to providing direct patient care in those areas. By leveraging OSHPD's workforce investments, California is positioned to address potential workforce shortages and deficits in training and cultural engagement in an expeditious manner to enable the initiatives to achieve their goals.

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In March 2013, The California Endowment announced its commitment to provide OSHPD $52 million[84] over three years to increase the supply and capacity of health care providers in underserved communities through a variety of strategies, including training. Providers include allied health and frontline workers, mental health, advanced practice clinicians, and physicians. In order to help address health disparities, The California Endowment intends that the majority of their funding support increasing cultural competency and diversity of health providers. Among other things, some funds will be used to support health professions training programs that:

- Support for model expansion and innovations in training multi-professional teams that deepen language and cultural competence, expand practice, prioritize equity and prevention, and prepare trainees for practice in underserved urban, rural and geographically isolated places
- Expand capacity through innovative technology including e-referrals, telehealth, electronic medical records, mobile health, and video medical interpreting, etc.
- Support linkages and collaboration between public health and clinical professionals
- Provide support, technical assistance for practice redesign (including EHR support and training, operations redesign and online curriculum for medical assistants and other team members)

OSHPD will be an integral partner during the planning phase of the SIM initiative to identify optimal locations for health homes for complex patients in order to maximize the use of both The Endowment and SIM funds. Similarly, as the Accountable Care Community initiative identifies eligibility criteria for interested communities, OSHPD staff will be a part of that process.

c) The State will identify opportunities to support workforce training to meet initiative objectives/needs. As outlined in each of the key initiatives, training of various workforce personnel will be needed to ensure successful implementation. As mentioned in the Maternity initiative above, there are several efforts underway to help providers continually improve in this area, most notably through the California Hospital Association, the California Maternal Quality Care Collaborative and large hospital systems.

The spread of health homes for complex patients will require workforce training in team-based care, care management processes, integrated behavioral health, patient risk stratification, care coordination and collaboration across services and organizations, including community services, and performance monitoring through the use of electronic health records. Several nonprofit organizations in the State (see preceding Health Homes for Complex Patients section) currently provide technical assistance in most of these areas; for-profit vendors are the main purveyors of assistance for use of electronic health information.

Training the incumbent workforce in palliative care is another area of high need. California is fortunate to be home to the newly-established Institute for Palliative Care at the California State University, San Marcos. Working in partnership with the Institute and the California HealthCare Foundation, a leader in advancing policy and practice in palliative care, the SHCIP will accelerate the dissemination, integration and take-up of palliative care training and curricula through a wide variety of professional societies and training programs that can reach

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physicians, nurses, social workers, and frontline workers, such as community health outreach workers. A train-the-trainer model will be explored.

4. Use of CalSIM Testing Funds

CalSIM testing funds would be used primarily to enhance various workforce training efforts, as delineated above. There are readily available technical assistance suppliers for most training areas in the state. Testing funds would also support work with community health workers and promoter organizations on how to effectively incorporate them into health care settings. Several of the initiatives will be developing and implementing payment reforms that will include reimbursement for community health workers. There are several models that other States have utilized, many of which require some form of certification.[85] Certification is a complex and controversial subject within community health workers. For example, some believe that it provides legitimacy and provides a career ladder. Others are concerned that a certification process may diminish community health workers' connections to residents.

Because of the potential of community health workers to enhance team-based care in a variety of settings and for a variety of populations, the State will lead a process to engage community health workers across the State, as well as with other health care professionals, insurers and payers to explore employment models, financing mechanisms and training and certification issues. The outcome of this process will be a set of recommendations for how community health workers can best be utilized and supported throughout the State in an ongoing and sustainable way.

B. Health Information Technology and Exchange Building Block

1. Background

Health information technology and exchange (HIT and HIE respectively) are vital components for achieving greater health care clinical integration and efficiency, as well as improving quality and accountability, key goals of the SHCIP. HIT/HIE facilitates payer-provider information flow that enable better care coordination, patient-centered care, and population health management. Through federal and state support, California has made significant strides in the spread of electronic health records (EHRs) and the exchange of clinical information. In particular, an estimated $1.54 billion in federal incentive payments have been invested in California since October 2011 to support the adoption of electronic health records, develop trainings and operational policies, and stimulate health information exchanges.[86] Moreover, California continues to demonstrate innovative ways to advance HIT/HIE within both the public and private sectors.

EHR and HIE Uptake

The Office of the National Coordinator (ONC) reports that in California, 49 percent of nonfederal acute care hospitals have adopted at least a basic EHR, compared to 44 percent of hospitals nationally.[87] The Centers for Medicare and Medicaid Services (CMS), reported that in California, as of August 2013, an estimated 30,000 eligible professionals have received incentive payments, plus 9,400 professionals in Kaiser Permanente, which qualifies as a Medicare Advantage plan. In total, an estimated 40,000 individual providers—an estimated 50% of practicing professionals—have received incentives.[88] Additionally, a survey performed by the

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California Primary Care Association found that 19 percent of community clinics have partially implemented an EHR. While adoption of EHRs is increasing, gaps still remain across the state.

Similarly, gaps exist with respect to HIE. In response to the state's geographic scale and variation, California's approach to HIE is a "bottoms up" model achieved by privately driven, publicly assisted efforts at both the community and enterprise levels. At the time of this report, 17 community health information organizations (HIOs) (e.g., Tulare-Kings-Fresno-Madera HIE) are operational or in the planning stage and 20 enterprise/private HIOs (e.g., Dignity Health, University of California) are up and running. (see **Appendix III** for list). In California, an estimated 25 of 38 million residents live in areas where information exchange is a reality.

The recently formed California Association of Health Information Exchanges (CAHIE) lists among its goals an assurance that "all providers of health-related services have the opportunity to participate in exchange and interoperate with other providers of care for patients in common," as well as "ensure health information exchange is secure and respects the privacy rights of individuals". CAHIE has been supported with technical assistance, funded through the ONC's state cooperative grant, from the California Health and Human Services Agency's Office of Health Information Integrity (CalOHII).

CalOHII has held several statewide Stakeholder HIE summits, bringing thought leaders together for 'pulse checks' in producing an updated California Health Information and Exchange Strategic and Operational Plan (the most recent dated May 2013). This Plan outlines a coordinating role for the State – led by both CalOHII and the Department of Health Care Services – to align EHR/HIE work across the state, including supporting CAHIE in making operational policy recommendations for all organizations participating in e-health activities.

Additionally California has served as a core participant in demonstrating interstate exchange through work with the National Association of Trusted Exchanges (NATE). Many of California's patients seek care in neighboring states of Oregon, Nevada and Arizona; the work of NATE is providing critical functions in making patient information across state borders despite differing state laws. This work has also been funded under grants administered through ONC efforts.

2. *Current Initiatives Underway*

Several noteworthy initiatives related to health information technology and exchange with a particular focus on quality measurement, improvement, and in some cases payment incentives include:

(1) The CHHS Agency HIE Plan focused on connecting state government with HIE activities in the state by developing three use cases to highlight the many information exchanges currently occurring in support of CHHS programs. With support from ONC, the plan focused on three use cases: a) a population – foster children; b) a condition – stroke; and c) a situation – emergency preparedness. This has served as a guide for additional work including obtaining an Interoperability Grant from the Administration of Children and Families; development of a roadmap for integration of Medi-Cal with statewide health information exchange; and support of a pilot to engage electronic exchange of information for emergency response.

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(2) California participated in the ONC HIT Trailblazer initiative. This six-month effort focused on CHHS activities and produced a catalogue of baseline programs, infrastructure, and metrics relevant to data measurement and reporting, quality improvement, and payment reforms. Deliverables, which were completed in May 2013, included infrastructure goals, strategies, action steps, and a work plan. Key "next steps" agreed upon with ONC were to harmonize the Trailblazer work with that of CHHS's HIE Plan (see above), and seek opportunities for advancing the goals and strategies across DHCS and other departments/agencies.

(3) A partnership between the Integrated Healthcare Association (IHA) and CalOHII to demonstrate a health plan use case for HIE. CalOHII has partnered with IHA in a targeted demonstration initiative focused on a use case, which works with HIEs and utilizes direct query architecture to allow systematic, streamlined, and timely data collection and data sharing between physician organizations, hospital and health plans. The data exchanged will include clinical and administrative data, including admission, transfer and discharge notifications, and will be used to improve coordinated case management and facilitate timely transitions of patients across care settings. It will also be used for performance measurement and analysis - important to health plans such as Medicare 5 Stars ratings at the provider level.

(4) The Integrated Healthcare Association's (IHA) inclusion of meaningful use metrics in its pay-for-performance program. Since 2011 IHA has included HIT-related metrics in its commercial pay for performance program. The Meaningful Use of HIT Domain requirement counts for 30% of the total performance points. Additional requirements for 2014 have been adopted for next year.

(5) A recently launched state public health reporting gateway. On October 1, 2013 the Department of Public Health announced the launch of a CDPH Provider Registry and Gateway to assist eligible professionals and hospitals in meeting public health objectives under Meaningful Use. These include requirements related to immunization reporting and future electronic lab reporting to the state's public health registries. This work was funded by ONC HIE grant dollars.

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3. Objectives and Targets

Similar to the workforce building block, the scope and scale of needs with respect to HIT and HIE are sweeping. Although significant progress has been made with the more than $1.5 billion in federal investments directly to providers to date, much remains to be done. Given the needs, the action steps here are targeted and designed to specifically support the delineated SHCIP initiatives.

4. Action Steps

a) Technical assistance will be provided to high-need entities and geographies developing health homes for complex patients. In order to provide patient-centered coordinated care, a health home will require robust EHR/HIE capabilities. Practice transformation technical assistance will include customized on-the-ground experts to assist providers' specific to use of technology for medical home modeling. HIE strategies will be of particular importance in areas where providers currently accept fee-for-service reimbursement and in underserved areas with complex patients.

b) Third-party business case analyses of how technologies can produce savings will be developed and promoted. California has been a leader with respect to leveraging technology and information exchange in the areas of telehealth and mobile-health (such as sharing lab work and other tests across providers to avoid duplication). Some health plans are documenting savings with e-referrals and uses of telehealth and mobile-health. Proof of concept pilot findings, such as the IHA-CalOHII demonstration mentioned above, will be documented and widely shared with a goal of rapid spread of such successes. Particular attention will be paid to the application of telehealth and mobile-health in health homes for complex patients.

c) The state will commission research regarding options for the state to consider in ensuring data can continue to be collected, comparable to fee-for-service data, to inform cost and quality of care improvement efforts on a statewide basis. As California continues to reduce the level of fee-for-service reimbursement throughout the state, this will enable the state to not only maintain but increase the level of data it currently obtains directly from providers.

5. Use of Testing Funds

A portion of CalSIM funds would support the provision of technical assistance, focused on under-served areas. In addition, to reach a greater number of health homes, CalSIM funds will be used to develop a tool kit that will identify a range of HIT options for health homes, which are developing under different models, from fully integrated systems to rural clinics. CalSIM funds would also be used to carry out the business case analyses as well as the data collection report, and disseminate them, as appropriate, to purchasers, plans and providers.

C. Enabling Authorities Building Block

The majority of initiatives proposed in this SHCIP builds off existing innovations and activities underway in California and can be implemented without significant changes in authorities. The LGHC report was intended to spur voluntary, collaborative action, particularly in the private sector, and the SHCIP, as a multi-payer effort, is designed with the same philosophy. Therefore, most of the system and payment reforms can be accomplished through contractual arrangements. To the extent that changes in authority could facilitate faster, broader, or deeper spread of transformation (or should a need rise during the implementation process), these changes will be explored.

1. Health Homes for Complex Patients

A key element of the Health Homes for Complex Patients initiative is taking advantage of Section 2703 of the Affordable Care Act. Assembly Bill 361 was recently signed into law on October 8, 2013. The bill provides the Department of Health Care Services with authorization to create a health homes program, subject to federal approval, building on the research it has conducted with a federal planning grant.

2. Palliative Care

California intends to pursue a Medicare hospice waiver to allow Medicare enrollees to obtain concurrent palliative and curative care; currently, Medicare enrollees must forgo curative care in order to receive hospice benefits. Also, the State may pursue a demonstration program similar to that authorized under Section 3140 of the Affordable Care Act, "Medicare Hospice Concurrent Care Demonstration Program," which establishes a demonstration program

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allowing patients eligible for hospice care to receive all Medicare services during the same period of time in which they receive hospice care.

3. *Workforce*

The final rule for Medicaid essential health benefits required under the Affordable Care Act expanded the scope of non-physician providers that can be reimbursed by Medicaid for preventive services.[89] California is reviewing the final regulation for potential implementation, which would allow for reimbursement of preventive services by additional non-physician providers, such as Community Health Workers and other frontline workers. This rule would be particularly helpful for the ACCs to utilize Community Health Workers.

4. *All-Payer Claims Database*

As described below, there may be a need for legislative or regulatory activity related to the development of an APCD. Legislation can increase the number of providers and payers submitting data into the system, as well as the probability of minimum levels of accuracy/ validity, as evidenced by other states. For example, Maine initially only authorized creation of an APCD to gain understanding of payments relative to charges, but expanded the legislation for broader policy use based on the initial success of the system.[90] However, given the time involved in enacting legislation and the effort already underway through the California Healthcare Performance Information System, the SHCIP will initially pursue a voluntary approach.

D. All-Payer Claims Database Building Block

1. *Background*

As of 2009, 11 states had implemented a fully operational APCD.[91] By 2011, Kansas and Oregon implemented APCDs,[92] three other states were in the process of implementing APCDs, and thirteen others had demonstrated strong interest in implementing an APCD.[93] A California APCD would provide a vehicle to create greater consistency, transparency, and monitoring of trends in health care costs and performance, benefiting all sectors of the health care system. Consumers need consistent, comparable information on health plan and provider performance, cost, and outcomes. Purchasers and payers need timely data to formulate new payment methodologies. Both CalPERS and Safeway, for example, have adopted reference pricing for select procedures (joint replacement, colonoscopy, cataract, advanced imaging and select lab tests), establishing a maximum price that they will contribute towards select procedures.[94,95]

Value-based purchasing requires complete data for accurate and effective benchmarking to achieve high program performance. Few purchasers are positioned to generate this type of information on their own. Health systems, providers, and ACOs need better information to gather, assess, and act on data to measure quality, provider performance, and outcomes. Public health professionals and communities need data to monitor population health and policymakers need comprehensive data on disease incidence, treatment costs, and outcomes.[96] Complete and integrated data supports comprehensive analysis and comparisons of outcomes across populations, providers, and regions of the State that would be housed in the database. Such information will be helpful in assessing regional performance in preparation of the Secretary and state program directors' annual accountability meetings. Further, it will allow all

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stakeholders to better gauge the extent to which fee for service payments are shifting toward value based payments.

2. LGHC Goals

An APCD supports the following LGHC goals and indicators.

Lowering the Cost of Care: Making Coverage Affordable and Aligning Financing to Health Outcomes
Transparent information on both the cost and quality of care
Most care is supported by payments that reward value

3. Current Activities Underway

The California Healthcare Performance Information System (CHPI)—a non-profit, public benefit corporation—has already begun the process of measuring health care quality using multiple plans' claims data. CHPI collects and aggregates claims and eligibility data from California's three largest health plans, Anthem Blue Cross, Blue Shield of California, and UnitedHealthcare. As the only Medicare Qualified Entity in California, CHPI includes Medicare information for California Medicare beneficiaries.[97] CHPI also collects data from California Public Employees' Retirement System (CalPERS), the largest employer purchaser of health benefits in California and the second largest in the nation.[98] CHPI is governed by a multi-stakeholder board which represents health plans, purchasers, consumers, and providers.[99]

4. Objectives and Targets

The key objective for this building block is to create an APCD data set within 6 to 12 months, in order to expand analyses for performance measurement and reporting.

5. Action Steps

There are currently two options for creating an APCD in California. Each will be explored with the goal of creating a robust database.

a) The State will meet with CHPI representatives to identify common interests for a potential public-private partnership on an APCD, similar to a model developed in Colorado. The State team has already approached CHPI about a possible partnership. Governance, data sharing requirements, and uses are the top three issues that need to be addressed in expanding CHPI to a statewide all- or multi- payer claims database. CalPERS already serves on the CHPI board; Covered California and the Department of Health Care Services will engage in discussions to identify what changes will be needed for an expansion.

b) The State will consider legislative options. While a voluntary approach is the preferred path, if there is not agreement on a public-private partnership, the State team will explore alternatives, including legislation to establish a state APCD similar to those in other states. In addition, legislation may be needed to require all payers in the State to participate – whether in CHPI or another entity. Eight of the 11 states that had implemented an APCD by 2009 did so through legislation requiring payers to submit data in compliance with other federal and state regulations, with some allowing for an "opt out" waiver or exception for certain entities.[100] The other three states (Wisconsin, Washington, Louisiana) established an APCD through private entities, allowing for voluntary participation by the payers.[101] In 2011, Kansas and Oregon also

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implemented APCDs through legislation requiring payers to submit data.[102] Data submitted usually includes medical claims, pharmacy, and dental, among others, and the entities submitting data include commercial payers, third-party and self-funded administrators, Medicare, and Medicaid. To ensure compliance, those states requiring submission of data imposed a fine and/or sanctions imposed by the state for failed compliance.

c) CHPI (or other host of APCD) will develop the database and conduct analyses needed to achieve SHCIP goals and monitoring. As a statewide claims database, the first task will be to identify those data sets most relevant to SHCIP goals and indicators and prioritize the development of analyses and tracking systems to be able to report progress to the State and all stakeholders.

6. *Use of Federal Testing Funds*

A California HealthCare Foundation report estimates that the annual maintenance cost for an APCD in California will be $1.5 to $4.7 million.[103] The cost of maintaining an APCD increases incrementally for every plan that is added to the database. CHPI was initially funded with a community grant from Blue Shield of California; each participating health plan helps maintain CHPI and PBGH contributes on behalf of its member purchasers.[104] If the CalSIM grant is awarded and CHPI is pursued as an APCD, testing monies will support adding additional plans to the database. CalSIM monies will also fund data analyses that provide information to complete the SHCIP framework and for other purposes as outlined above.

E. Public Reporting Building Block

1. *Background*

Making information transparent and publicly available is one of the guiding principles of the SHCIP. Throughout the proposed initiatives, public reporting plays a fundamental role. The California Office of the Patient Advocate (OPA) is a statewide resource that strives to inform Californians about making better health care decisions by producing annual report cards on health plan and medical group quality, both in clinical and patient experience categories.[105] The State of California would like to enhance OPA's mission to encompass all three components of the Triple Aim.

2. *LGHC Goals*

The Public Reporting building block supports the following LGHC goal and indicator.

Lowering the Cost of Care: Making Coverage Affordable and Aligning Financing to Health Outcomes
Transparent information on both the cost and quality of care

3. *Objectives and Targets*

The primary objectives of this building block is to create a vehicle for monitoring and tracking LGHC indicators and other metrics and to enable stakeholders and the public to utilize data to improve quality and outcomes.

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4. Action Steps

The OPA will be the home for a dynamic LGHC and SHCIP website which will (a) publicly report on the six LGHC goal areas and 39 measurable indicators, (b) identify "hot spots" that experience greater health disparities, and (c) spotlight promising initiatives. OPA is committed to building and growing a comprehensive, consumer-friendly website that incorporates existing and expanded performance metrics related to LGHC and the SHCIP, as appropriate.

5. Use of Federal Testing Funds

Federal testing funds would be used to advance the development of the OPA website that will monitor trends and report on health care quality, costs, and population health, and present the information in a manner that is easily accessible to everyone.

F. Payment Reform Innovation Incubator Building Block

1. Background

California is fortunate to have an experienced nonprofit organization dedicated to payment reform development, testing, and reporting. The Integrated Healthcare Association's (IHA) mission is to create breakthrough improvements in health care services for Californians through collaboration among key stakeholders. IHA plays multiple roles including promoting accountability and transparency through health care standards, measurement, rewards, and providing information to third parties for public reporting; convening by bringing together leaders from key sectors of health care in California to promote innovation; and serving as a project incubator by initiating, coordinating, and managing projects that advance solutions for delivery system challenges.

Among its many initiatives, IHA has developed a 10-year-old healthcare Pay for Performance (P4P) program that rewards hospitals, physician practices, and other providers with both financial and non-financial incentives based on performance on select measures. These performance measures cover various aspects of healthcare delivery: clinical quality and safety, efficiency, patient experience and health information technology adoption. IHA recently included an efficiency metric for total cost of care for physician organizations in its P4P program.

2. LGHC Goals

Supporting the Payment Reform Innovation Incubator will help the State to achieve progress on the following LGHC goal and indicator.

Lowering the Cost of Care: Making Coverage Affordable and Aligning Financing to Health Outcomes
Most care is supported by payments that reward value

3. Objectives and Targets

The key objective of this building block is the development and spread of payment reforms that will better align incentives that reward value --for both the four initiatives and over the long term--to achieve cost, quality and outcome goals. It will be accomplished by bringing together a

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wide range of stakeholders, especially payers and providers, and building consensus on the selection of metrics, data collection methods, and incentives.

4. Action Steps

IHA has significant capacity and a reputation for being able to facilitate payer, provider, and purchaser collaboration on technical issues, resulting in valuable information and outcomes for all participants. The SHCIP will build on this key asset by supporting IHA to explicitly serve as a forum or incubator for system-wide payment reform activities. In addition, IHA would support select SHCIP initiatives with regard to payment reform activities.

a) IHA will expand to include additional stakeholders, such as the Department of Health Care Services, public hospitals, and possibly the Veterans Administration and military representation **(**CalPERS and Covered California are already members of IHA**).**

b) IHA will identify methodologies to measure the SHCIP goals of reducing fee-for-service payments and increasing payments that reward performance and value in partnership with researchers at the University of California, Berkley.

c) IHA will facilitate the development of an agreed-upon approach to measure total cost of care for non-managed care organizations.

d) IHA will support initiative-specific activities, including:

- Identifying appropriate metrics in line with the SHCIP Maternity Care initiative to include in IHA's P4P program and a hospital value-based purchasing incentive program for non-managed care products. This effort would be done in partnership with the California Maternal Quality Care Collaborative and appropriate stakeholders.
- In partnership with organizations implementing Health Homes for Complex Patients, identifying key metrics and data collection methods for this initiative to measure patient outcomes, payer payment innovations, and the degree to which value-based payments are in place.
- In partnership with appropriate stakeholders, including the California HealthCare Foundation and the Coalition for Compassionate Care, identifying potential bundled payment approaches for select oncology services, as well as potential relevant metrics to include in the P4P program.

5. Use of Federal Testing Funds:

Federal testing funds will enable IHA to carry out the various activities described above, including logistical and convening support; technical assistance regarding payment reform methods and options; data analysis and metrics development; and, potentially partner support.

V. Financial Analysis

This section of the State Health Care Innovation Plan (SHCIP) describes potential health care savings from the Maternity Care, Health Homes for Complex Patients, and Palliative Care initiatives. Savings were not estimated for Accountable Care Communities because this initiative consists of two or three pilot sites that are to be specifically defined and established.

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Because many aspects of the savings calculations are common to all initiatives, this section begins with an overview of the general approach for estimating savings and provides total savings for all initiatives. Later sub-sections describe details for each initiative, including the estimated target population, additional assumptions, and potential reductions in expenditures over a three-year period. Further specifics for each calculation, as well as assumptions and caveats, are found in **Appendix IV**.

A. Calculation Overview

Estimated savings for each initiative can be generally described by the following equation:

[Total Savings] = [Target Population] * [Engagement Rate] * [Savings Per Member Per Year]

Target Population. The target population varies by initiative and is estimated for each of five regions in California and for each major payer type (Medicare, Medi-Cal, and Commercial).[106] The five regions, which are described in detail in **Appendix IV (**Regional Costs by Payer and Sub-appendix C**),** include: Bay Area/ Sacramento, Central Valley/ Central Coast/ North, Inland Empire, Los Angeles, and Orange County/ San Diego.

Engagement Rate. The engagement rate is the percentage of the target population participating in the respective initiative. This can be difficult to estimate because participation is largely voluntary and depends on payers, providers, and patients finding the value of participation greater than the incremental costs. For these reasons, the analysis uses conservative scenarios for potential engagement rates.

Savings Per Member Per Year. Savings per member per year (PMPY) estimates are based on figures obtained from the literature or targets recommended by organizations with expertise in the area. **Appendix IV** describes the methodology for obtaining these estimates in more detail.

B. Total Estimated Savings for all Initiatives

Using conservative assumptions, the total estimated medical expense savings for the three SHCIP initiatives is between $1.3 and $1.7 billion over three years (**Table V.1**). Approximately 85 percent of savings are attributable to Health Homes for Complex Patients, largely because the initiative spans all payers and includes the most costly persons.

Table V.1: Total Savings from all CalSIM Initiatives (2015-2017)

Initiative	Low Estimate	High Estimate
Health Homes for Complex Patients	$1,070M	$1,400M
Maternity Care	$60M	$98M
Palliative Care	$145M	$195M
Total	**$1,275M**	**$1,693M**

The initiatives listed above target about 8.1 million people enrolled in health plans, which cover 34.2 million people (out of a total population of 38.8 million) or 88 percent of Californians. The

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populations receiving the initiative interventions represent about 47 percent of California health expenditures and 24 percent of insured persons. However, the strategies were chosen specifically because they could leverage existing activity and promote the take-up of the most promising service delivery and payment reforms. Although the initiatives may be somewhat constrained in the three-year timeframe, they are designed to sustain and spread beyond the three years.

Moreover, the building blocks are intended to not only support the initiatives but promote system-wide change beyond the initiatives. For example the APCD will collect vital cost and quality data that will enable purchasers, payers, providers and consumers to make informed decisions, especially in combination with the Public Reporting building block. In addition, the robust accountability system, including public regional meetings, proposed by the SHCIP, has the potential to impact a far greater number of providers, health plans and payers—and ultimately, Californians--than those directly participating in the initiatives.

More detailed summaries of the total savings from each of the three CalSIM initiatives are presented below; additional details and assumptions may be found in **Appendix IV**.

1. Maternity Care Initiative

Over the three year period, Maternity Care is estimated to save California $60 to $98 million--$48 million for Medi-Cal and up to $29 million for commercial insurance with very minimal implementation costs. **Table V.2** displays the target population, estimated engagement rate, and savings per birth. More details about the methods for obtaining these estimates and savings calculations are included in **Appendix IV**.

Table V.2: Total Savings from Maternity Care – Details and Assumptions (2015-2017)

	Medicare	Medi-Cal	Commercial/Other	Total
Target Population (births, in 2015)	NA	350,739	258,972	609,711
Estimated engagement rate (the % increase over baseline by 2017)	NA	90%	15- 20%	NA
Savings (per birth)	NA	$2,861	$7,300	NA
Total projected savings (millions)	**NA**	**$48 M - $98 M**	**$11 - $29 M**	**$60 - $98 M**

2. Health Homes for Complex Patients Initiative

Over the three-year period, Health Homes for Complex Patients are estimated to save California up to $1.4 billion--$1.3 billion for Medicare, $63 million for Medi-Cal, and $47 million for commercial insurance. **Table V.3** displays the target population, estimated engagement rate, and savings PMPY. More details about the methods for obtaining these estimates and savings calculations are included in **Appendix IV**. Note that the savings PMPY is net savings, reflecting savings less the costs of providing health home services.

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Table V.3: Total Savings from Health Homes for Complex Patients - Details and Assumptions (2015-2017)

	Medicare	Medi-Cal	Commercial/Other	Total
Target Population (% of beneficiaries)	34.0%	10.5%	7%	NA
Estimated engagement rate (by 2017)	15-20%	15-20%	15-20%	15-20%
Savings (PMPY)	$1,000	$172	$77	NA
Total projected savings	**$986 – $1,1290 M**	**$48 - $63 M**	**$36 - $47 M**	**$1,070 – $1,400 M**

3. *Palliative Care Initiative*

Lastly, over the three-year period, Palliative Care is estimated to save California up to $190 million--$164 million for Medicare and $26 million for Medi-Cal with negligible implementation costs. **Table V.4** displays the target population, estimated engagement rate, and savings per discharge. More details about the methods for obtaining these estimates and savings calculations are included in **Appendix IV**.

Table V.4: Total Savings from Palliative Care - Details and Assumptions (2015-2017)

	Medicare	Medi-Cal	Commercial/ Other*	Total
Target Population (% of discharges)	6%	2%	NA	NA
Savings (per discharge)	$4,580	$4,580	NA	NA
Total projected savings	**$126 – $164 M**	**$ 20 – $26 M**	**NA**	**$145 - $190 M**

*Due to unavailability of Commercial/Other data regarding the percent of inpatient discharges appropriate for Palliative Care, the rows in this column were left blank.

VI. Conclusion

When the Let's Get Health California report was issued last December, it was intended to launch efforts up and down the State in support of the vision of California being healthiest state in the country. The State Health Care Innovation Plan is an important next step, which builds on the report and lays out four initiatives and six building blocks that, taken together, serve as a significant down payment on making the LGHC vision a reality.

These initiatives and building blocks are a complementary mix of specific interventions—targeted at some of the most costly aspects of the health care system—and system-wide improvements, which will enable California to track costs and quality over the long-term. Through the use of several key strategies—care coordination (including linking with community and social services), implementation of best practices, incorporation of lower-cost health providers where appropriate, and respecting patient preferences for care options—the plan will lower costs while improving health outcomes. Moreover, by targeting high cost

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patients, the SHCIP will produce significant savings – $1.3 to $1.7 billion over three years—a return of over 20-fold on the potential $60 million investment of a federal State Innovation Model testing grant.

Achieving the ambitious goals set out by this plan will require assertive leadership from the public, private and nonprofit sectors. California's public purchasers, including, the California Public Employees' Retirement System, Covered California, and the Department of Health Care Services, along with employers from the Pacific Business Group on Health, and payer partners, will jointly implement the key initiatives and building blocks. Medicare, as a major payer for many of the targeted populations, will also be invited to participate in these efforts. In addition, the SHCIP will actively engage other private sector purchasers, payers and providers, who are critical for enabling the initiatives to go to scale and take hold.

The robust stakeholder process begun during the LGHC process, and continued through the work groups convened as part of the SHCIP, has laid the groundwork for the kinds of collaborations needed to implement this multi-payer plan. The SHCIP is a rare opportunity to catalyze lasting change. By leveraging the momentum of dozens of innovative health system reform efforts already underway, the SHCIP will catalyze further progress and accelerate the spread of both delivery system and payment reforms.

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