State Innovation Model Design 2

KICK-OFF MEETING

MAY 5, 2015

The Health Innovation Journey

Costs: High, irrational, rising much faster than inflation

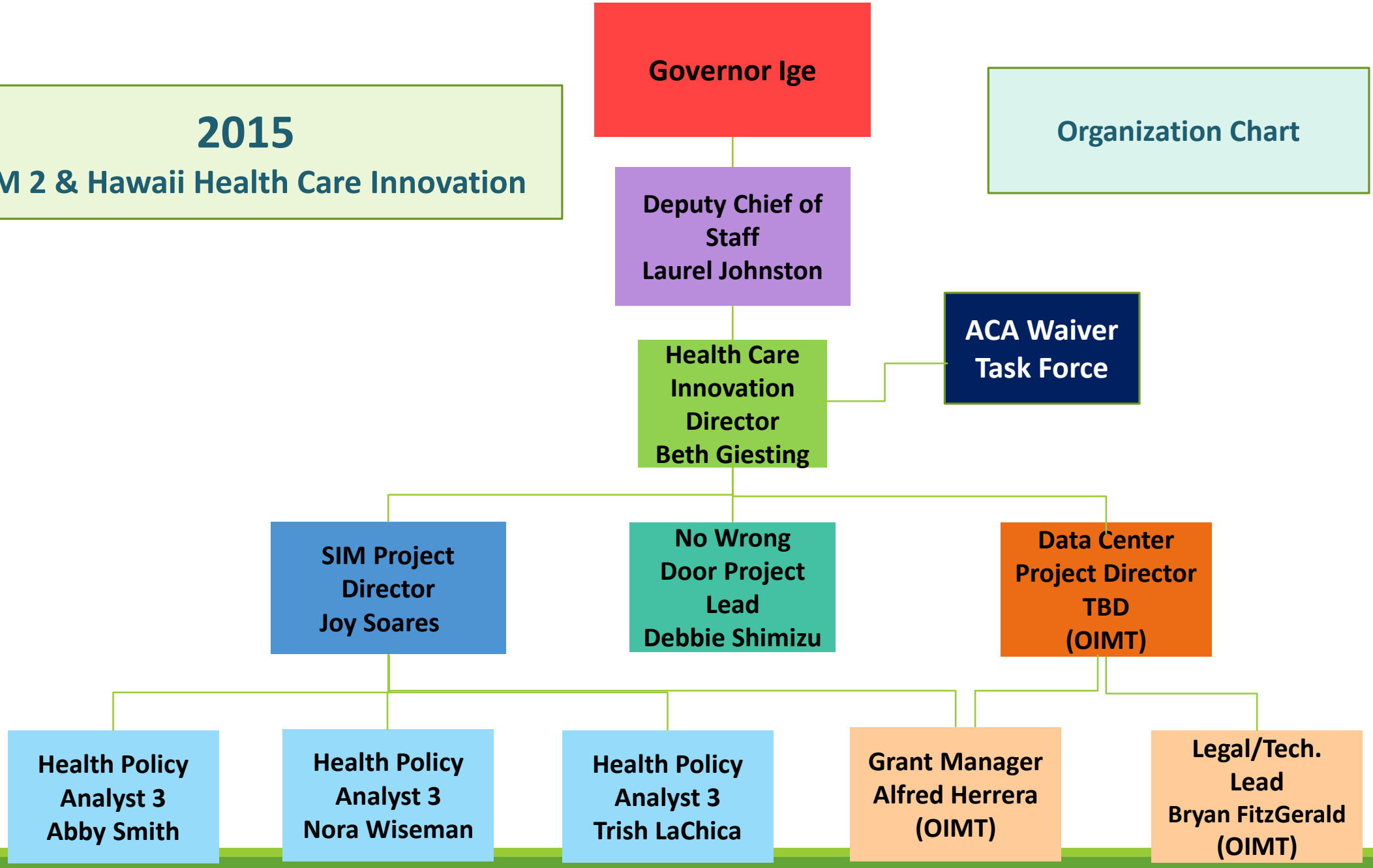
Quality: Fragmented, uneven, unsupported by evidence, unaided by IT

Health & Equity: Chronic disease; disparities in health status, coverage, access

Review: 2012 - 2014

2015
SIM 2 & Hawaii Health Care Innovation

Organization Chart



State Innovation Models (SIM) Initiative

Funded by **Center for Medicare & Medicaid Innovation** to design and test multi-payer models to transform the health care systems in the state.

Reaching for **Triple Aim**: quality, cost, health

Expectations:

- State-led
- Broad stakeholder input and engagement
- Accelerate health care delivery system transformation

SIM 2 Opportunity

TA, funds to develop *Hawaii-specific* Health Innovation Program

- Triple Aim + 1
- Maximizing federal dollars
- Connecting clinical care with population health
- Creating new workforce models
- Using IT and data to support improvement
- Identifying long-term home for innovation

SIM 2 Health Care Improvement Targets

Improve behavioral health via integration with primary care

Effective awareness, diagnosis and treatment for adult populations:

- Patients in primary care settings with mild to moderate behavioral health conditions
- Patients with chronic conditions in combination with behavioral health conditions

Improve oral health and access to preventive care

FOCUS IS ON MEDICAID

Rationale for BH Target

- You told us this was our biggest health care problem
  - Feedback from stakeholders, providers, community
  - Hawaii CHNA identified mental illness as #1 cause of preventable hospitalizations

- Prevalence
  - BH conditions disproportionately affect the most vulnerable populations
  - Nationally, 50% of Medicaid enrollees have a mental health diagnosis
  - At any time 1 in 4 US adults has a mental illness; half will be affected over the course of their lives

Rationale for BH Target

- Impact
  - People with chronic physical ailments are more likely to have mental illnesses and substance use disorders; conversely, people with mental illnesses and substance use disorders more frequently have chronic physical ailments.

- System doesn't address BH effectively
  - Nationally, PCPs diagnose only 1/3rd of patients who have BH issues
  - Nearly 40% of diagnosed patients get no care
  - While transformation in Hawaii is progressing, BH has largely been left out of innovations.

Rationale for BH Target

- Cost
  - Nationally, the cost to Medicaid for enrollees with co-occurring behavioral health and chronic medical conditions is 2-3 times higher; for those with diabetes it's 4 times higher
  - The cost for individuals with a BH diagnosis in Hawaii is three times higher (SIM 1 analysis)
  - Mental illness is a co-existing condition for 34% of potentially preventable hospitalizations and almost 10% of hospital readmissions in Hawaii (HHIC, 2012)
  - Total annual costs associated with potentially avoidable stays/visits in Hawaii (HHIC, 2012)
    - ER: $93 million (charges)
    - Preventable hospitalizations: $159 million (estimated cost)
    - Readmissions: $103 million (estimated cost)

Rationale for Oral Health Target

Half of Hawaii's children covered by Medicaid

- Low rate of preventive dental services
- Even lower rate of dental sealants

ER visits for OH up by 64% between 2006 -2012

- Cost >$2 million

Emergency-only services for Medicaid adults cost > $6 million (2013)

The Health Innovation Journey

- Managed care
- Patient-centered medical homes
- Value-based payment
- Integrated systems of care
- Social Determinants and Population-based care

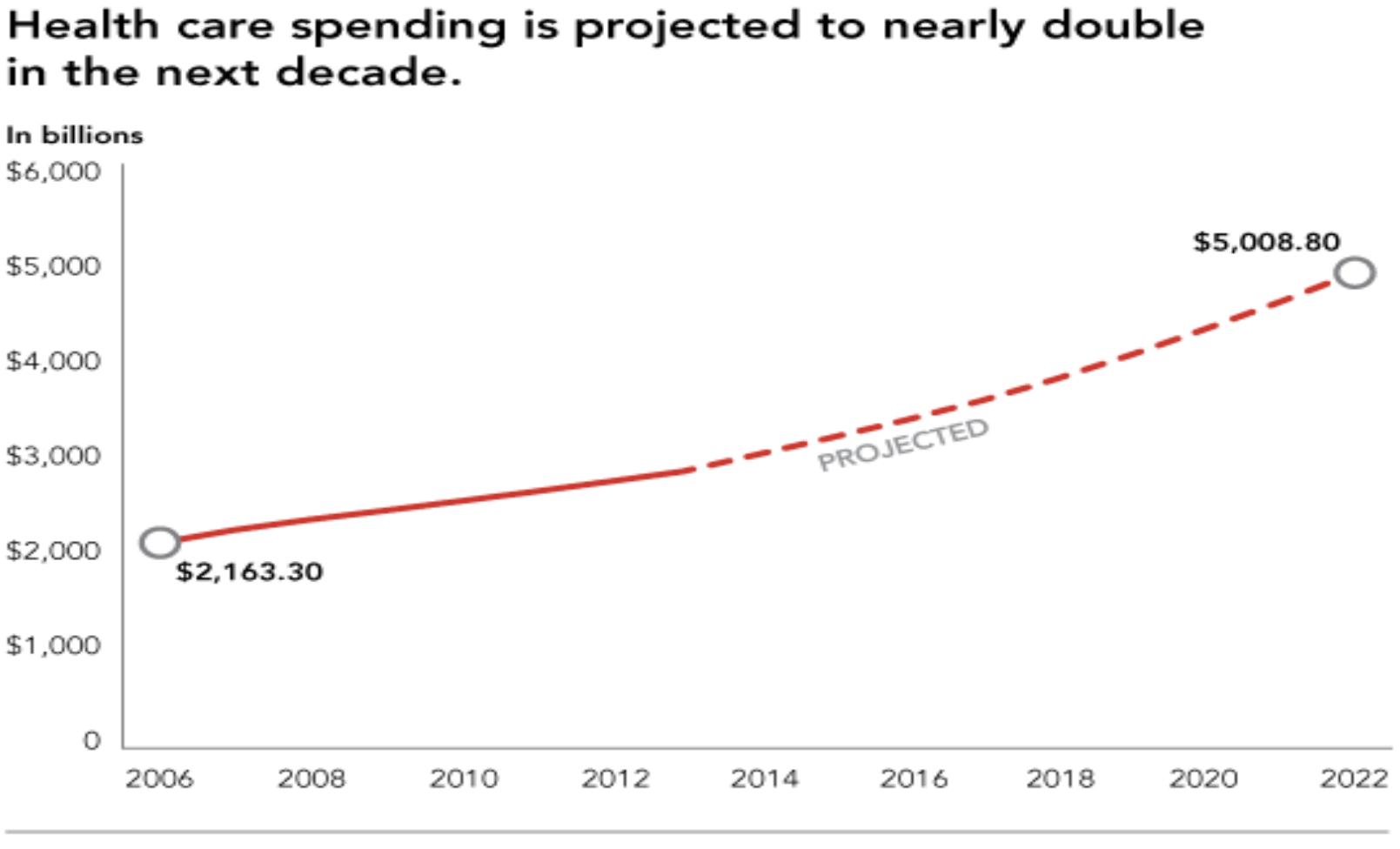
Bruce Goldberg, MD

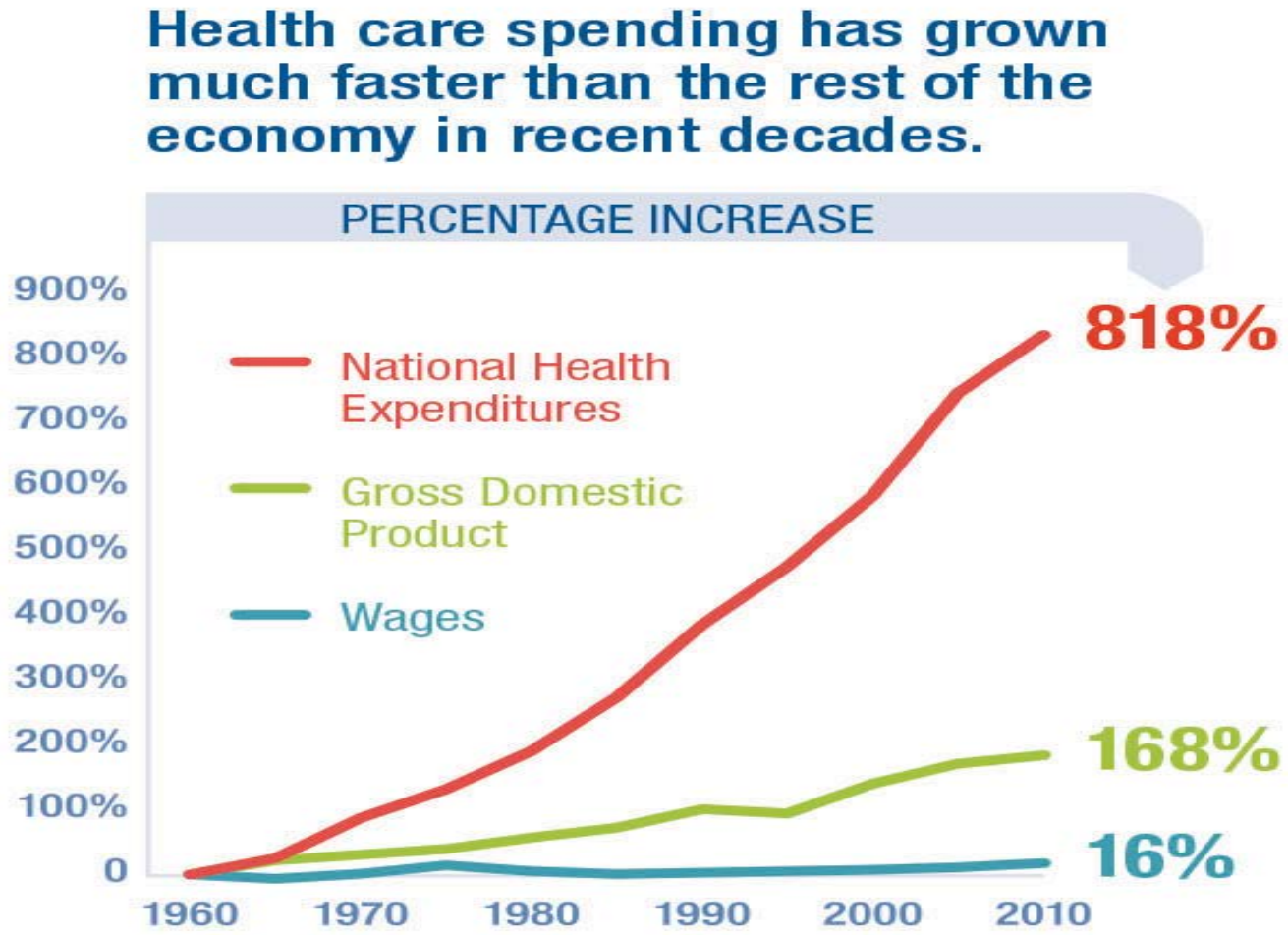
- Family practice physician focused on organization, delivery, financing health care
- Served 2 Oregon governors:
  - Director of Oregon Dept. of Human Services
  - Organized and led the Oregon Health Authority
- Author of ground-breaking Oregon Medicaid waiver with expected ROI of $5 billion over 5 years, featuring
  - Extensive community care coordination and accountability
  - Flexible investments in services and workforce

Another Pacific state's experience with health reform

Environment

- Health care costs rising faster than any other economic indicator
- Stealing precious $ from other important human endeavors
- Health care outcomes not what we wanted
- A belief that we could do better!

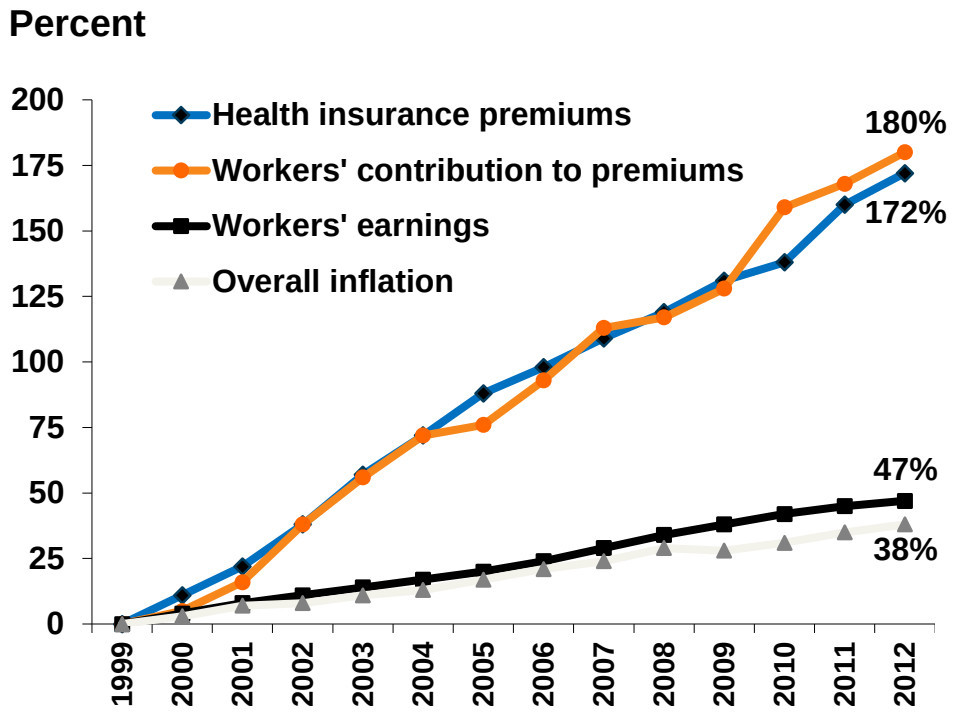

Health care spending is projected to nearly double in the next decade.
In billions
$6,000
$5,000
$4,000
$3,000
$2,000
$1,000
0
$5,008.80
PROJECTED
$2,163.30
2006
2008
2010
2012
2014
2016
2018
2020
2022
Notes: The health spending projections were based on the National Health Expenditures released in January 2013. The projections include impacts from the Affordable Care Act. Numbers may not add to totals because of rounding.
Source: Centers for Medicare & Medicaid Services, Office of the Actuary
THE HUFFINGTON POST



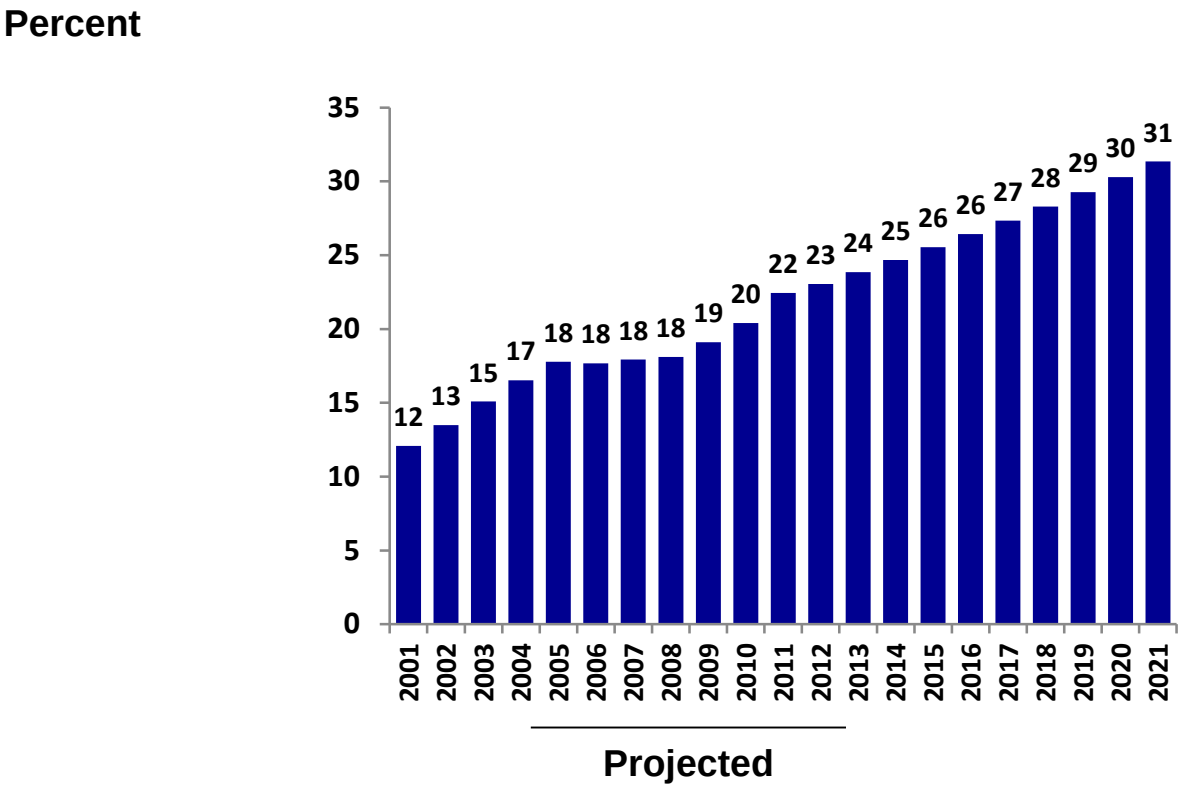
Source: McKinney, “Accounting for the Cost of U.S. Health Care” (2011), Center for American Progress

Exhibit 3. Premiums Rising Faster Than Inflation and Wages

Cumulative changes in insurance premiums and workers' earnings, 1999–2012



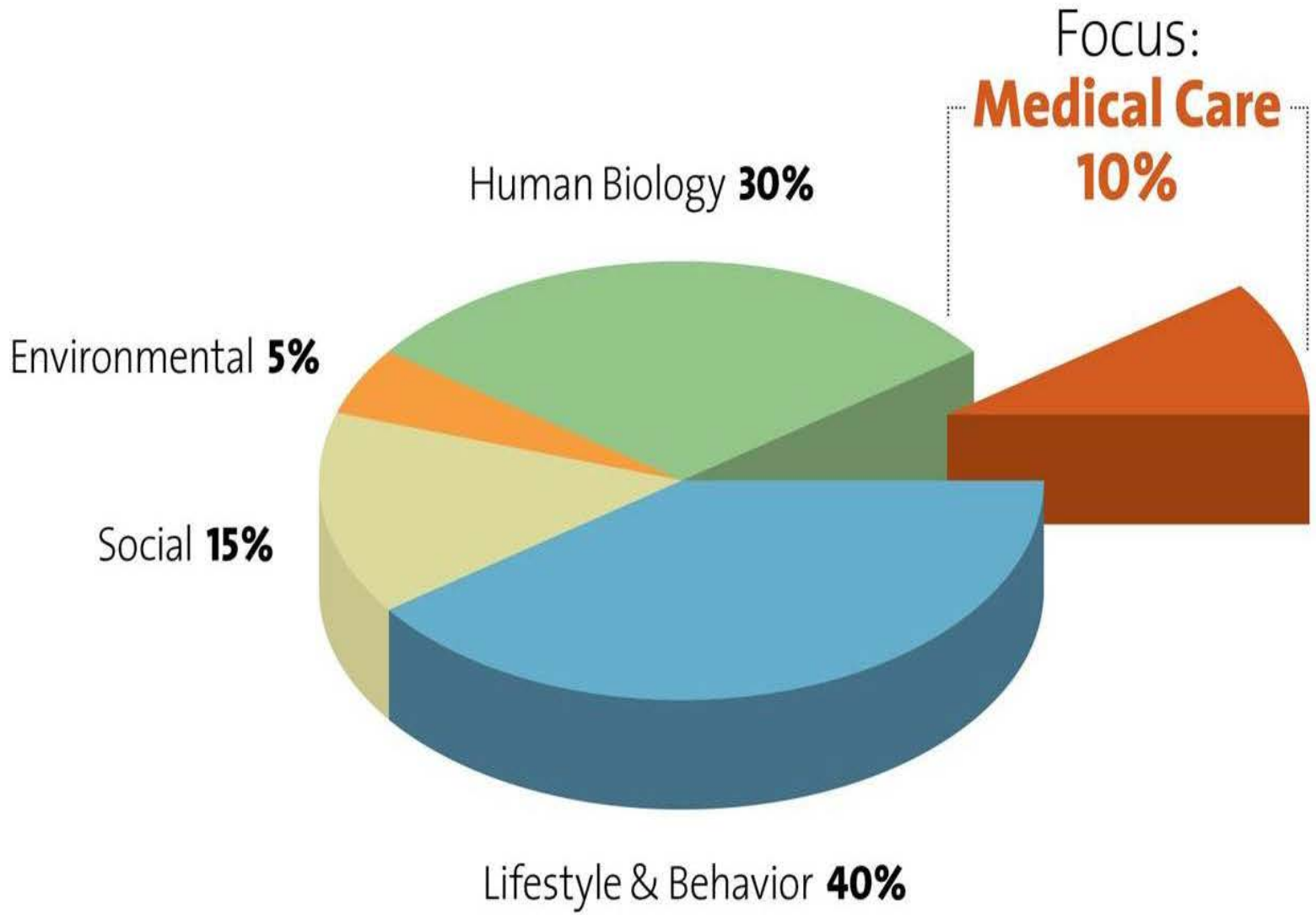
Projected average family premium as a percentage of median family income, 2013–2021



Sources: (left) Kaiser Family Foundation/Health Research and Educational Trust, *Employer Health Benefits Annual Surveys, 1999–2012*; (right) authors' estimates based on CPS ASEC 2001–12, Kaiser/HRET 2001–12, CMS OACT 2012–21.

Traditional budget balancing

- Cut people from care
- Cut provider rates
- Cut services


Focus:
Medical Care
10%
Human Biology 30%
Environmental 5%
Social 15%
Lifestyle & Behavior 40%

The Fourth Path

Change how care is delivered to:

- Reduce waste
- Improve health
- Create local accountability
- Align financial incentives
- Pay for performance and outcomes
- Create fiscal sustainability
- Provide patient-centered team based care

No child should have to go to the Emergency Room because of an asthma attack

Oregon's Coordinated Care Model

Coordinated care organizations

- The coordinated care model was first implemented in Oregon's Medicaid program: the Oregon Health Plan.
- There are 16 coordinated care organizations in every part of Oregon, serving the majority of OHP members; there are two CCOs also serving state employees (Public Employees Benefit Board members)
- Locally governed by a partnership between health care providers, community partners, consumers, and those taking financial risk.
- Consumer advisory council requirement
- Behavioral health, physical, dental care held to one budget.
- Ability to use Medicaid dollars flexibly to better meet consumer needs.
- Responsible for health outcomes and receive incentives for quality
- Global budgets that grow at no more than 3.4% per capita per year

Before CCOs	With CCOs
Fragmented care	Coordinated, patient-centered care
Disconnected funding streams with unsustainable rates of growth	One global budget with a fixed rate of growth
No incentives for improving health (payment for volume, not value)	Metrics with incentives for quality and access
Limits on services	Flexible services
Health care delivery disconnected from population health	CCO community health assessments and improvement plans
Limited community voice and local partnerships	Local accountability and governance, including a community advisory council

Federal Framework

- Establishment of CCO's as Oregon's Medicaid delivery system.
- Flexibility to use federal funds for improving health.
- Federal investment:
  - $1.9 billion with ROI of $4.9 billion

Oregon's Accountabilities

Savings:

- 2% reduction in per capita Medicaid trend
- No reductions to benefits and eligibility in order to meet targets
- Financial penalties for not meeting targets

Quality:

- Strong criteria
- Financial incentives (sticks and carrots) at CCO level
- Financial penalties for not meeting targets

Transparency and workforce investments

Accountability and Transparency for Oregon's CCOs

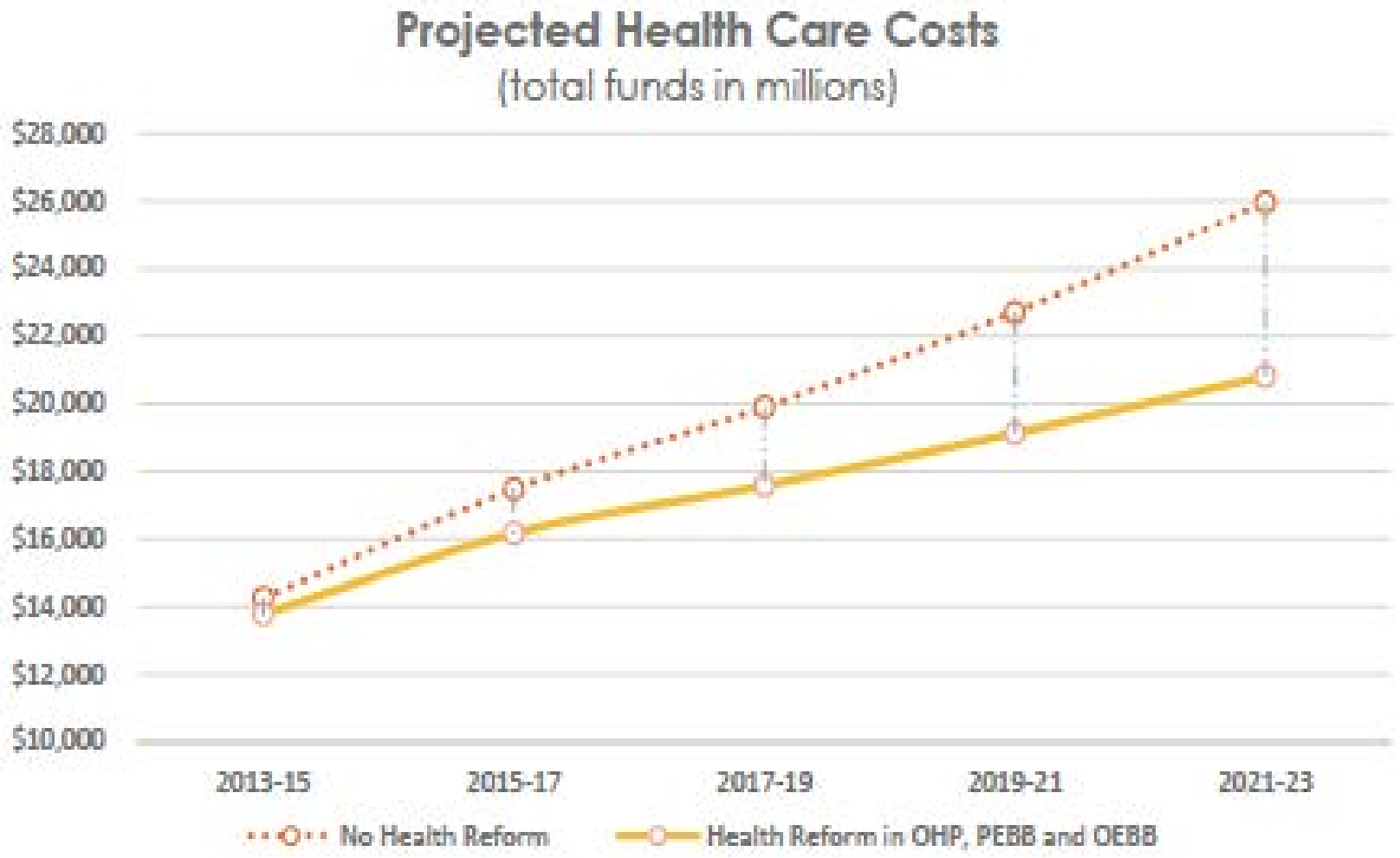
CCOs are accountable for 33 measures of health and performance

Results are reported regularly and posted on Oregon Health Authority website

CCO financial data posted regularly

Meeting the triple aim: what we are seeing so far…

- Every CCO is living within their global budget.
- The state is meeting its commitment to reduce Medicaid spending trend on a per person basis by 2 percentage points.
- State-level progress on measures of quality, utilization, and cost show promising signs of improvements in quality and cost and a shifting of resources to primary care.
- Race and ethnicity data shows broad disparities for most metrics – points to where efforts should be focused to achieve health equity
- Progress will not be linear but data are encouraging.

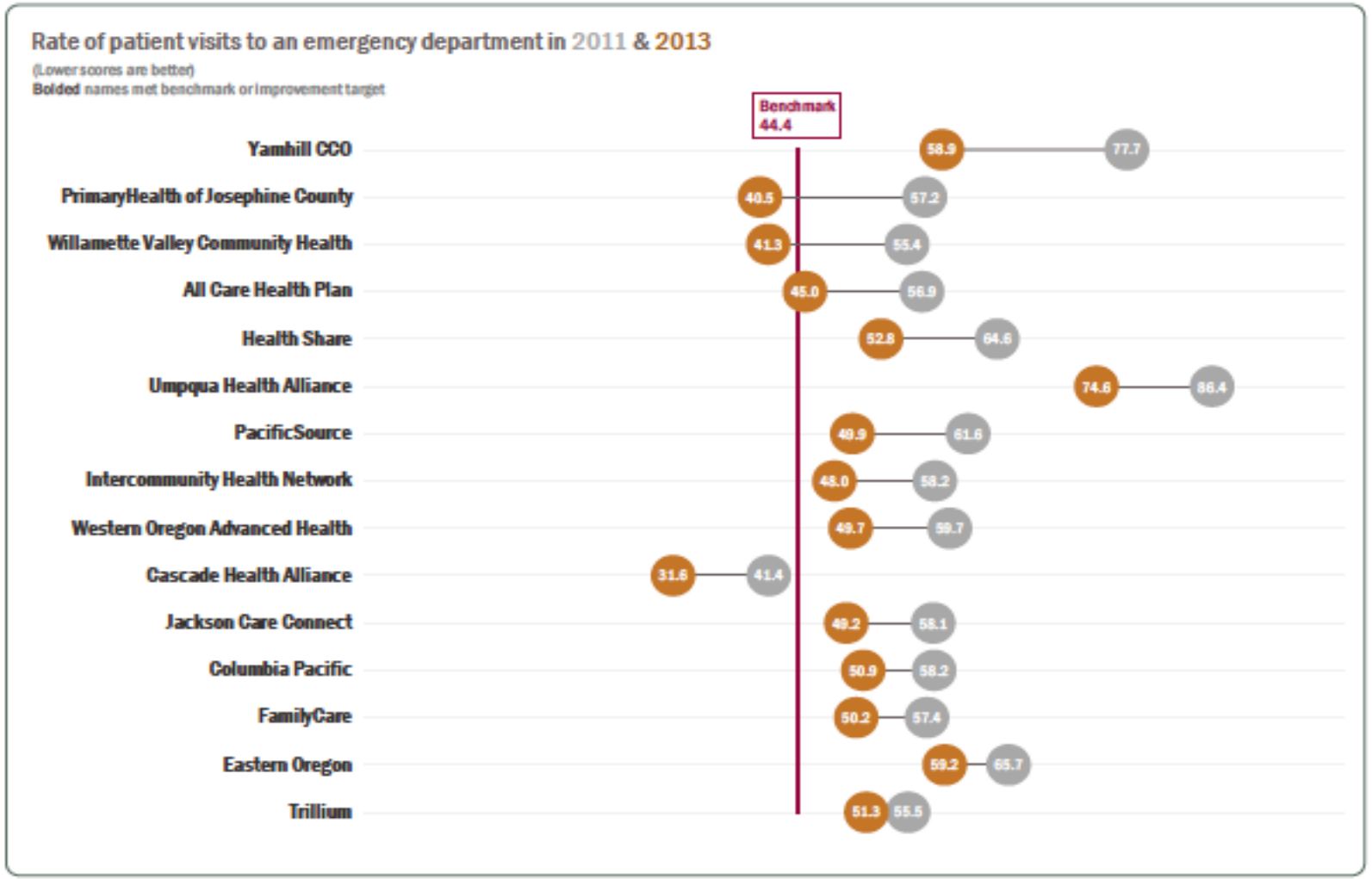

Projected Health Care Costs
(total funds in millions)
$28,000
$26,000
$24,000
$22,000
$20,000
$18,000
$16,000
$14,000
$12,000
$10,000
2013-15
2015-17
2017-19
2019-21
2021-23
No Health Reform
Health Reform in OHP, PEBB and OEBB

Progress to date

- ED utilization – visits ↓21%, costs ↓20%
- Primary care – visits ↑18%, spending ↑20%
- Adult hospital admissions: for asthma ↓39%, chronic lung disease ↓48%, heart failure ↓34%, short term complications from diabetes ↓9%,
- Patient-centered primary care homes enrollment ↑55%
- Developmental screening of children ↑ 68%

AMBULATORY CARE: EMERGENCY DEPARTMENT UTILIZATION

CCO Incentive and State Performance Measures



AMBULATORY CARE: EMERGENCY DEPARTMENT UTILIZATION

CCO Incentive and State Performance Measure

Ambulatory care: emergency department utilization

Measure description: Rate of patient visits to an emergency department. Rates are reported per 1,000 member months and a lower number suggests more appropriate use of this care.

Purpose: Emergency departments are sometimes used for problems that could have been treated at a doctor's office or urgent care clinic. Reducing inappropriate emergency department use can help to save costs and improve the health care experience for patients.

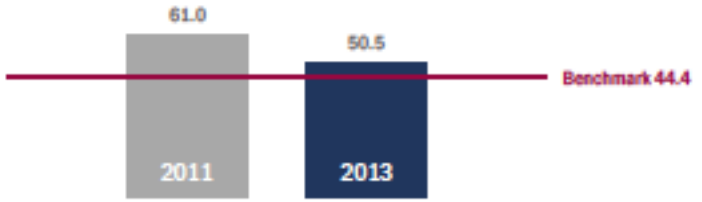
2013 data (n=6,476,701 member months)

This metric represents emergency department visits that occurred in 2013. Emergency department visits by people served by CCOs have decreased 17% since 2011 baseline data. Financial data (starting on page 81) is consistent in showing reduced emergency department visits.

All 15 CCOs met their improvement target on this measure showing a strong trend toward fewer emergency department visits and more coordinated care.

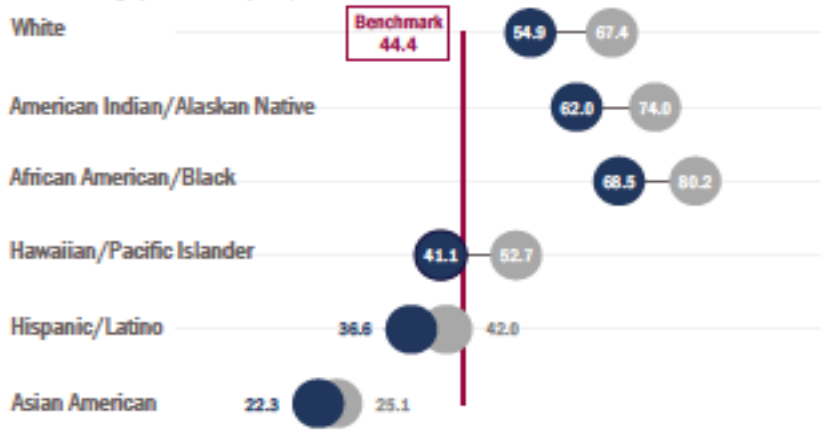
Statewide

(Lower scores are better)
Data source: Administrative (billing) claims
Benchmark source: 2012 National Medicaid 90th percentile



Race and ethnicity data between 2011 & 2013

(Lower scores are better)
Data missing for 7.4% of respondents
Each race category excludes Hispanic/Latino



Health care collaborators not competitors

Next steps

- Aligning care models, standards and reporting in Medicaid, Public Employee purchasing and insurance exchange.

- Leverage work to reduce costs, increase transparency in commercial market

Better Health and Value Through

- Innovation
- Focus on chronic disease management
- Focus on comprehensive primary care and prevention
- Integration of physical, behavioral, oral health
- Alternative payment for quality and outcomes
- More home and community based care, community health workers/non-traditional health workers
- Electronic health records – information sharing
- Tele-health
- New care teams
- Use of best practices and centers of excellence

Supports for Transformation

- Transformation Center and Innovator Agents
- Learning collaboratives
- Peer-to-peer and rapid-cycle learning systems
- Community health assessments and community improvement plan
- Non-traditional healthcare workers
- Transformation plans
- Primary care home support
- Technical assistance in addressing health equity

Just Some of the Challenges

- Time, resources and expectations
- Change is hard
- Behavioral health / physical health integration
- Integrating dental care
- Ensuring robust provider networks to meet client needs
- Transforming care and paying for outcomes
- Accounting for “flexible” services
- Anti-trust

And Some More…..

- Penalties for failure to achieve cost, quality and access benchmarks
- Training and using new health care workers
- Increasing consumer engagement and personal responsibility for health
- Health information exchange
- Integrating with early learning and education systems
- Personal responsibility for health

LESSONS LEARNED TO SHARE WITH OUR PACIFIC NEIGHBORS

- ACA creates opportunity for change
- Need structure and leadership
- Common vision is critical
- “It takes a village”
- Communicate early and often
- Federal support helps

YOUR STRENGTHS

- History of leadership in health reform
- Very cooperative health care sector
- Manageable size
- Good coverage and health status
- Engaged state leadership

YOUR CHALLENGES

- Do you have a burning platform?
- Data
- Geography
- Workforce

The future belongs to those who create it.

SIM Round 1 Plan

- Required to develop interventions that addressed 80% of Hawaii's residents
- More than 250 individuals from across the healthcare spectrum participated
- Behavioral health was identified as a priority
- State Health Improvement Plan (SHIP) was completed
  - 50,000 foot level
  - Comprehensive in order to meet requirements, but not detailed enough to be implemented

SIM Round 2 Plan

- Building on successes of Round 1
- Narrowing focus so we can achieve goals
- Focused on developing a detailed implementation plan
- Developing a plan that will work for Hawaii
- Committed to developing a plan that is sustainable
- Utilizing experts and consultants that specialize in innovation
- Continue strong stakeholder engagement involvement

Consultants

- **Dr. Bruce Goldberg and Tina Edlund**
  - Facilitate strategic planning process
  - Provide expertise on key areas such as maximization of federal funds, behavioral health integration, and developing and funding HIT infrastructure
  - Contract will end by June 30th
- **Large contractor (TBD) will help develop:**
  - Behavioral health integration blueprint
  - Cost analysis and return on investment
  - Evaluation and monitoring plan
  - Write SHIP
  - Contractor will start on July 1st

Steering Committee

- Oversee the development of the SHIP
- Develop a plan to structure and fund health care innovation efforts
- Provide direction on the communication and outreach plan
- Develop a plan that will maximize federal funding
- Approve metrics and evaluation plan

Delivery and Payment Committee

- Develop behavioral health integration blueprint
  - Develop delivery and payment models that address improving early detection, diagnosis and treatment of mild to moderate behavioral health conditions
  - Identify a plan to improve the capacity of PCPs to address mild to moderate behavioral health conditions
  - Identify plan to improve the care coordination of patients with complex needs (also known as super-utilizers) and linkage with treatment and community support services

Population Health Plan

- Oversee the development of a Plan for Improving Population Health
  - Identify measure goals, objectives and interventions that will address the underlying social determinants of health for adults with the following conditions/characteristics:
    - Mild to moderate behavioral health conditions
    - Diabetes (requirement)
    - Obesity (requirement)
    - Tobacco use (requirement)
  - Identify measures
  - Develop a plan that is sustainable

Workforce Development

- Develop a plan to help build a workforce that will support the delivery and payment model innovations.
- In particular, develop a plan to support “emerging” professions including community health workers, clinical pharmacists and other professions.

HIT

- Develop a statewide HIT plan that supports comprehensive health care transformation
- Develop an implementation plan that supports interventions identified in the SHIP and Population Health Plan

Oral Health

- Identify strategies that improve access to dental care and address prevention of dental caries in children
- Identify strategies to provide dental coverage to low-income adults

Timeframe

- Performance period: February 1, 2016 – January 31, 2016
- **February – May**
  - Hired and orientated staff
  - Developed RFP for large contractor and procured Goldberg contract
  - Dr. Goldberg facilitates meetings
- **June**
  - Committees start
  - Dr. Goldberg submits report

Timeframe

- **July - August**
  - Large contractor starts in July
  - Focus groups completed
  - Community conversations completed
- **September – November**
  - Committees receive financial analysis, focus group and community conversation reports
  - Draft plans circulated and reviewed by all committees
- **December – January**
  - Complete writing of SHIP
  - **Celebrate!**

Final Product - SHIP

- Description of State Health Care Environment
- Report on Stakeholder Engagement and Design Process Deliberations
- Health System Design and Performance Objectives
- Value-Based Payment and/or Service Delivery Model
- Plan for Health Care Delivery System Transformation
- Plan for Improving Population
- Health Information Technology Plan
- Workforce Development Strategy
- Financial Analysis
- Monitoring and Evaluation Plan
- Operational Plan

Questions?

Beth Giesting
Health Care Innovation Director
Beth.Giesting@Hawaii.gov
808-586-0009/808-492-0529

Joy Soares
SIM Project Director
Joy.Soares@Hawaii.gov
808-286-5755