

California State Health Care Innovation Plan

March 31, 2014



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 (Innovation Plan) 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.

The Let's Get Healthy California 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 Innovation Plan includes advancements toward these two goals, as well as a third goal of reforming payments that reward value.

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.

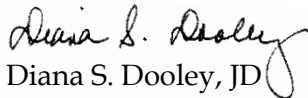
The Innovation Plan presented here centers around four initiatives, which focus on different aspects of the health care system that experience particularly high costs—uncoordinated care for people with complex chronic conditions, maternity care, and end of life care. Through the greater use of team-based 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 a cost and quality reporting system, 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 curve. These activities will, collectively, 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 we work toward our vision to be the healthiest state in the country.

A handwritten signature in black ink, reading "Diana S. Dooley". The signature is fluid and cursive, with a large, stylized "D" at the beginning.

Diana S. Dooley, JD

Secretary

California Health and Human Services Agency

ACKNOWLEDGEMENTS

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 HealthCare 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. Much appreciation also goes to the California Department of Health Care Services information technology team who made our webinars possible from January 2013 until May 2013.

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 (Innovation Plan), which will form the basis of a forthcoming application for a three-year State Innovation Model Testing grant. The Innovation Plan 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 Innovation Plan. The work groups were based on the goals identified by the Let's Get Healthy California (LGHC) 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 Innovation Plan is far shorter than the 10-year plan envisioned by the LGHC Task Force. For this reason, the Innovation Plan 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 occurring both in the public sector and the private sector marketplace. Specifically, the Innovation Plan 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 reduce pure fee-for-service reimbursement; and*
- *Demonstrate significant progress on the LGHC Dashboard, especially those indicators related to the proposed initiatives included in the Innovation Plan.*

The Innovation Plan 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 Innovation Plan's implementation. Together these purchasers and their payer partners represent close to 80 percent of all California health expenditures, enabling the Innovation Plan to have a significant influence in aligning incentives across payers toward greater value, quality, and improved outcomes.

The Innovation Plan is conservatively projected to yield savings of \$1.4 to \$1.8 billion over three years – a return of over 20-fold on the potential \$60 million SIM investment. It is likely that the Innovation Plan 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.

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, 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 LGHC Task Force and at a more refined level by regions.

To promote transparency, accountability, and healthy competition, the Secretary of the Health and Human Services Agency, select state departments, including 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, clinics or health centers, and others, such as local employers and state elected officials representing each region. These public meetings will be a forum for reviewing the progress of regional metrics related to both the preceding overarching targets and the specific initiatives described in this plan. The meetings will also offer 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 Innovation Plan 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 core organizing principle underlying all of the **initiatives** is 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. 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, 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, which 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, which will serve as a

vehicle to pool and leverage funding from a variety of sources for long-term sustainability.

The **building blocks** 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, 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. The building blocks are:

- **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 an enhanced 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 Innovation Plan. Because the initiatives proposed in the Innovation Plan build off of existing innovations and activities underway in California, most can be implemented without significant legislative and regulatory changes. Two requests for Medicare waivers are included.
- **Cost and Quality Reporting System.** Build on current efforts to create a robust reporting system that promotes transparency and monitors trends in health care costs and performance.
- **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 Innovation Plan is designed to take advantage of California's history of inventiveness 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 Innovation Plan will help catalyze further progress to reduce the growth rate of health care expenditures and firmly place California on the road to becoming the healthiest state in the country.

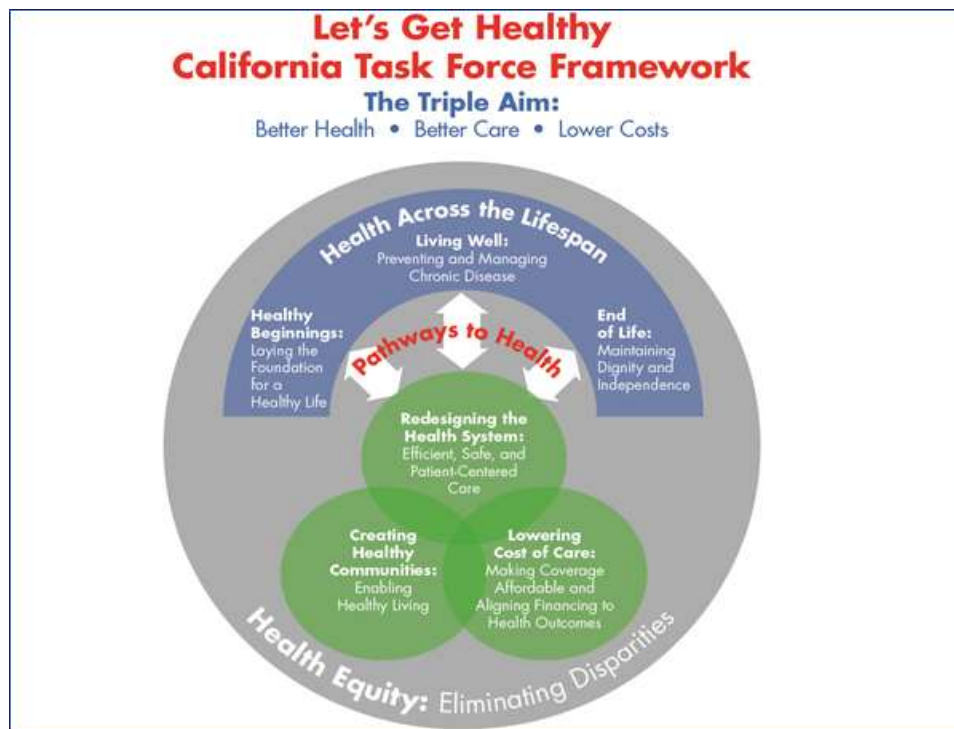
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I. Introduction and Overview of California's State Health Care Innovation Plan

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**, the first strategic direction is comprised of three goals that 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 the importance of integrating 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



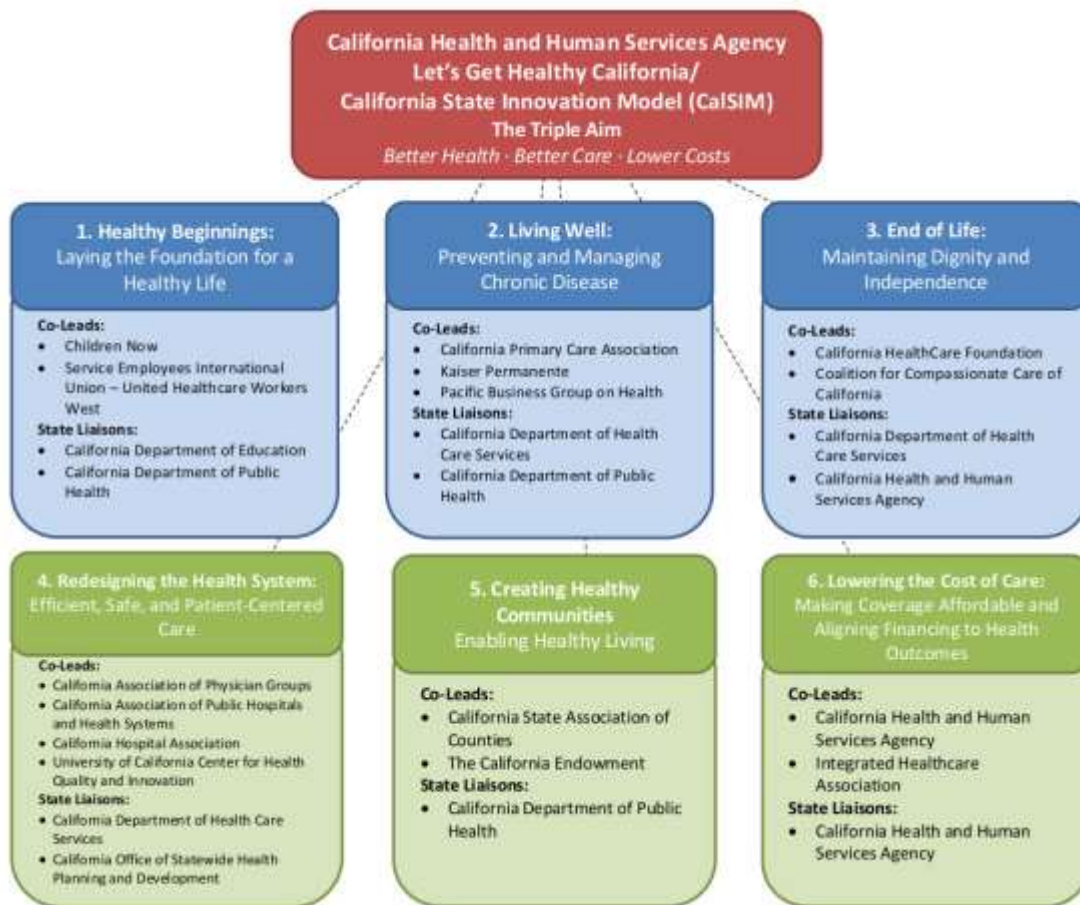
The goals and priorities set forth by LGHC serve as the foundation for the State Health Care Innovation Plan (Innovation Plan) developed under a Center for Medicare and Medicaid Innovation (CMMI) State Innovation Models (SIM) Design award. The Innovation Plan is designed to meet the requirements of a State Innovation Model Testing grant. Testing grant criteria include using a multi-payer approach to demonstrate a return on investment within three years, reaching a preponderance of Californians, and building upon existing initiatives.

California plans to submit a proposal, based on the Innovation Plan, to CMMI following release of a funding opportunity announcement.

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 Innovation Plan'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.

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 meeting in March, consisted 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 Innovation Plan. Work groups were also tasked with developing private sector recommendations to complement the payment reform and public policy recommendations.

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



The Innovation Plan identifies key leverage points and opportunities to accelerate progress. While the three-year timeframe of the Innovation Plan is shorter than the 10-year timeframe envisioned by the LGHC Task Force, the Innovation Plan represents a significant gateway to the full range of system transformations needed to achieve the 10-year goals. For this reason, the Innovation Plan has dual goals: it focuses on initiatives designed to achieve savings in the short-term and 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. Because of 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 Innovation Plan'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 Innovation Plan initiatives. The Innovation Plan provides an important 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 Innovation Plan is projected to yield savings of \$1.4 to \$1.8 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 Innovation Plan 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 the rate of growth in the Gross State Product by 2022. Together with numerous other private and public sector initiatives, the Innovation Plan will help catalyze statewide efforts to reduce the growth rate of health care expenditures.
2. ***Increase value-based contracts that reward performance and reduce 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 or value-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 Innovation Plan payment reforms 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 for two primary reasons: (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 Innovation Plan will seek to obtain consensus on certain value-based payments for key initiatives and 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 Innovation Plan; the work groups, which made recommendations for the Innovation Plan, 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 Innovation Plan 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 employers from the Pacific Business Group on Health, will implement and monitor the key initiatives outlined in this plan.² The Secretary of Health and Human Services and select state department leaders, including the directors of the purchasing programs, along with the Integrated Healthcare Association, will host annual regional meetings with heads of hospitals, health plans, county health departments, physician groups, clinics or health centers, 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 Innovation Plan. Both private and public major purchasers are concerned about the considerable delivery system consolidation that has occurred in California's marketplace and its subsequent effect 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 the major factors that 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, which aim to move the system away from paying for the volume of health care services and towards paying for value: payment reform and delivery system reform.³ The vision of the Innovation Plan 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 underlying Values and Guiding Principles, displayed in **Figure I.3**, have guided the planning process for the Innovation Plan. 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 enhance 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.

Figure I.3: Innovation Plan Target, Vision, Values and Principles

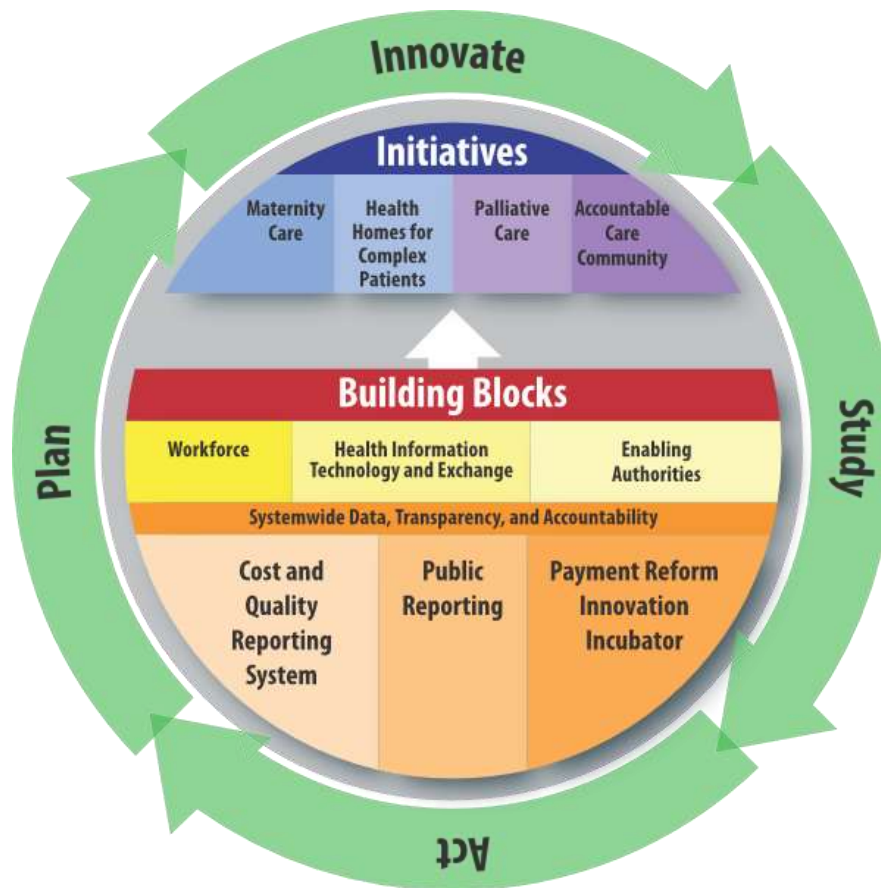


D. Overview of Initiatives and Building Blocks

The Innovation Plan 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 Innovation Plan.

Figure I.4: Innovation Plan Framework



1. Initiatives for Delivery System Transformation

The Innovation Plan includes a limited set of interventions to drive delivery system reforms and the 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 Innovation Plan 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/or 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 Innovation Plan enables California to bring greater attention to these populations, especially racial and ethnic populations that suffer from the greatest health disparities.

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

First, the Innovation Plan 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 Innovation Plan 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 health care costs in the last year of life exceeded, by far, any other single year of life. And those costs have increased since 2006, which is the most recent year for which data are available. 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 life, 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, 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, which 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, which will serve as a vehicle to pool and leverage funding from a variety of sources for long-term sustainability.

In advancing these initiatives, the Innovation Plan 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-Commercial
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 Innovation Plan focuses on those efforts that can most directly impact and advance the four initiatives

outlined 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 cost and quality reporting system, 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 Innovation Plan, 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 an enhanced 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 Innovation Plan. Because the initiatives proposed in the Innovation Plan build off of existing innovations and activities underway in California, most can be implemented without significant legislative and regulatory changes.
- **Cost and Quality Reporting System.** Build on current efforts to create a robust reporting system that promotes transparency and monitors trends in health care costs and performance.
- **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 Innovation Plan 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 Innovation Plan 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 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 Innovation Plan 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 Innovation Plan 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 new approaches proposed in the Innovation Plan. 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 Innovation Plan 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 has an unusual combination of characteristics 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, California's 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 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

As a result of the state's high managed care penetration, a relatively young population, a high uninsured rate, and relatively 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). Although Medi-Cal per capita spending is below the national average (\$4,569 compared to \$6,826 in 2009), California's 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 makes up 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 the 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 2007.¹⁴ 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 managed care. Across the three payer types, California outperformed the nation on at least 59 percent of indicators. California's commercial HMOs had the highest score of the three payer types, with better performance than commercial HMOs nationwide on 70 percent of indicators,

followed by Medi-Cal Managed Care and then Medicare Advantage. For full details including the actual performance scores, see **Appendix III, Table III.4**.

Data on California's health care costs and health system 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 are estimated to account for 32 percent of nonelderly, insured individuals (9.5 million out of 30.0 million) and 25 percent of spending (\$41.7 billion out of \$166.5 billion) in 2014.¹⁷ These estimates are conservative and state public purchasing power is likely higher.

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 Anthem Blue Cross, Blue Shield, Health Net, and United Healthcare collectively insuring an additional 30 percent. In contrast, in the Medi-Cal market, the three largest payers (Kaiser, Anthem Blue Cross, and Health Net) together comprise less than 35 percent, where Kaiser is less than 5 percent of the market. The remainder of this market consists of a variety of other primarily locally-based insurers.¹⁸

A major characteristic of California's health care market is the significant managed care penetration – 48 percent of all people are enrolled in managed health plans compared to only 23 percent nationally.¹⁹ Among California's Medicare beneficiaries, 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 insured 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. Rates of Medi-Cal and private/other coverage also vary across the state, although there is less variation in Medicare coverage. Regions with higher percentages of uninsured also have higher Medi-Cal coverage rates, likely reflecting lower incomes in these regions. These figures do not account for recent enrollment in Covered California, the state's health insurance exchange. California was a lead state in enacting legislation and implementing its exchange to

extend coverage to Californians; to date more than 2.5 million enrollment applications have been received through the exchange.²⁰

E. Initiatives and Demonstrations Underway

The California health care environment offers fertile ground for testing a range of reforms and for generating momentum to scale 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.6a** 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 (CTGs)*, 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 programs.

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 provided health care coverage for more than 650,000 uninsured individuals through county-based coverage programs as a transition to implementation of the Affordable Care Act, effective as of January 1, 2014. 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.²¹ 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: developmental disabilities 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.6b**. The California Innovation Plan builds upon this extensive activity already underway to leverage programs for maximize impact.

III. Proposed Payment and Delivery System Initiatives

This section describes the four proposed 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 502,000 babies are born each year in California.²² Nearly half (46 percent) of these births are paid for by Medi-Cal.²³ 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.²⁴ Despite a variety of efforts to bring down the cost of maternity care, particularly by reducing elective Cesarean sections, progress has been slow.²⁵

- 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.²⁶
- Each year in California an estimated 7,000 early elective deliveries — defined as deliveries occurring later than 36 and before 39 weeks gestation — had a scheduled Cesarean or induction without medical indication.²⁷
- Cesarean section deliveries in California rose from 22 to 33 percent between 1998 and 2008 and now total more than 165,000 per year.²⁸ While the statewide cesarean delivery rate is 33 percent, some outlier hospitals have rates as high as 71.4 percent.²⁹
- 44 percent of California hospitals do not offer a meaningful Vaginal Birth After Cesarean (VBAC) opportunity (fewer than 5 percent of attempted VBACs) 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.”^{30,31}

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; native born Hispanics have significantly lower rates of VBAC than other groups.³² Similar racial variation is observed at the University of California, San Francisco hospital³³ and among Kaiser Permanente members in Southern California hospitals.³⁴ Recent analyses have noted significant variation in these rates among California hospitals indicating that improvement opportunities exist.^{35,36} Further, evidence shows that hospitals and health care systems adopting initiatives aimed at reducing early elective deliveries, scheduled births, and elective cesareans are obtaining very promising results.^{37,38}

2. LGHC Goals

The Maternity Care initiative relates to the following LGHC goals and indicators.

Healthy Beginnings: Laying the Foundation for a Healthy Life
Early Elective Delivery Measure
Cesarean Section Rate for Low-Risk Births
Vaginal Birth After Cesarean Delivery Rate
Unexpected Newborn Complications in Full-Term Babies
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 participated 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. 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, as of January 2014, 47 out of 252 acute care hospitals, representing 28 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.³⁹ Similarly, Dignity Health reduced elective early deliveries from 7 percent to 1 percent across their entire health system.⁴⁰

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 at four hospitals and medical groups in 2014. This work builds off of a similar effort in Washington State's Medicaid program, which reduced payments for uncomplicated Cesarean sections to that of vaginal births. In addition, this year, IHA is including maternity metrics into its Pay-for-Performance program, which currently applies to physician organizations.

4. Objectives and Targets

Expert stakeholders and the state team identified three objectives for improving Maternity Care performance through a coordinated multi-payer effort. The objectives are:

- *Reduce rates of early elective deliveries to achieve a target of 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 Innovation Plan.

- ***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. The target is to reduce the statewide average of 27.7 percent to 23.9 percent (the Healthy People 2020 target for this measure).
- ***Reduce repeat Cesareans by incentivizing an increase of VBACs, where safe and appropriate, from 9 percent to 11 percent by the end of 2017.***

5. Action Steps

The Innovation Plan will build upon and complement the aforementioned efforts through the following action steps:

a) State purchasers and select large employers and health plans will encourage and eventually 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 drive quality improvement activities. These outcome data will be made publicly available. 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 implement a Value-Based Purchasing program. 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 backstop 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 will 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.

c) The state will develop a process for identifying outlier hospitals and oversee an annual review of them. The process will require these hospitals to develop a performance improvement plan for which they may receive technical assistance as desired.

d) Purchasers will explore and partner with appropriate programs that engage pregnant women on healthy deliveries to achieve the preceding objectives. There are a variety of programs nationally and within California aimed at improving the health of pregnant women and babies (e.g., March of Dimes programs, CMMI-funded Text4baby). While evidence for many programs is limited, Medi-Cal and other large purchasing programs will consider a review of these efforts and possibly partner with select programs to improve health outcomes for beneficiaries.

6. Use of Testing Funds

If awarded, CalSIM testing funds will support:

- Universal enrollment in the CMQCC Maternal Data Center.

- Widespread development and implementation of a value-based payment program to include multiple payers.
- Implementation of a statewide maternity performance improvement team to audit outlier facilities and assist hospitals and providers in meeting the quality targets.
- Review and possible support of a patient engagement program(s).

B. Health Homes for Complex Patients Initiative

The Health Homes for Complex Patients initiative is designed to 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 the public and private sectors.

1. Background

As previously noted, across all California payers, approximately 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.⁴¹ Studies show that coordinating care through health homes for complex patients improves the patient experience and health outcomes while controlling costs.^{42,43} 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.⁴⁴ 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.⁴⁵

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.⁴⁶ **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, and 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 were still enrolled in Medi-Cal two years later and continued to exceed \$10,000 in annual expenditures. A higher percentage of Medicare beneficiaries have multiple chronic conditions than other payers. Moreover, many high-cost enrollees are 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.⁴⁷

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.⁴⁸ Although 48 percent of 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 groups, primarily in California. To date roughly half are in place.

The California Primary Care Association is supporting its member clinics to implement health homes through a Patient-Centered Health Home (PCHH) Initiative. Through this initiative, CPCA provides its members with training and technical assistance, including practice

transformation coaching. To date, approximately 10 percent of 900 clinic sites have implemented the PCHH.⁴⁹ In partnership with The California Endowment, the Center for Care Innovations 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. More recently, the Center for Care Innovations has partnered with the Institute for Healthcare Improvement and the California HealthCare Foundation to develop health homes for high-cost, complex patients within nine safety net clinics.

There are other innovative efforts, as well. For example:

- The Partnership Health Plan and Redwood Community Health are testing two care manager models – one in which the care manager is hired by the health plan and embedded in 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 expanded access to individuals who did not qualify for Medi-Cal prior to January 1, 2014, through the county-based Low Income Health Programs. Over 650,000 low-income uninsured residents received care and were enrolled in a medical home under this waiver. They became Medi-Cal beneficiaries when California expanded Medi-Cal to a new category of adults on January 1, 2014. Finally, California’s Department of Health Care Services (DHCS) is launching a three-year project to promote coordinated health care delivery. Through Cal MediConnect, up to 456,000 Medi-Cal beneficiaries in eight selected counties who are seniors or people with disabilities and also receive Medicare benefits (dual-eligibles) will receive coordinated medical, behavioral health, long-term institutional, and home-and community-based services through an 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:

- *Spread health homes for complex patients in California by the end of 2017 that demonstrate measureable value.*

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. Therefore, a clear definition will be developed in the first months of the testing phase, should California be awarded a grant. 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 highest risk patients will also prove helpful in identifying potential candidates for palliative care within a health home. Although this intensive care model does not target patients who are generally well, the functionality of instituting a team-based approach with enhanced coordination among entities, will ultimately benefit broader patient care.

5. Action Steps

The Health Homes for Complex Patients initiative will spread these types of health homes through the following action 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.⁵⁰ The required functionality will include providing/linking to adequate palliative care services. 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 partner with 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;
- Create criteria and a selection process to select health homes for complex patients.
- 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.

C. Palliative Care Initiative

The Palliative Care initiative is designed to better address patient preferences for individuals facing advanced illness with significant risk of death within the next year. Together with the Health Homes for Complex Patients Initiative, this effort aims to identify patients in hospitals, long-term care facilities, or the community, who may benefit from and desire palliative care services, and offer them comprehensive palliative care by people who are trained in this area.

1. Background

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.

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 65.⁵¹ Although 70 percent of Californians would prefer to die at home, only 32% do,⁵² and a statewide survey revealed that only 44 percent of Californians felt that their loved one's wishes were completely followed at the end of their life. The majority of Californians expressed interest in speaking with their doctor about palliative and hospice care.⁵³

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 wide geographic variation within the state.^{54,55} California statewide rates for hospitalizations during the end of life (measured by patient deaths associated with ICU admission) as opposed to dying at home or in hospice care, are higher than national rates.⁵⁶ As with hospice care, there is geographic variation in such hospitalizations.

A number of initiatives have resulted in a significant proportion of public hospitals (63 percent); offering palliative services. According to an estimate by the Berkeley Forum, however, only 20

percent of potentially appropriate patients have access to community-based palliative care services.^{57,58}

This mismatch of patient preferences and care delivery also means that health care costs toward 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, as of 2010, Medicare reimbursements per decedent in the last six months of life are well above the national average (\$46,686 in California versus \$36,392 nationally).⁵⁹

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 financial and benefit incentives, which exacerbate the misalignment.^{60,61} The nature of reimbursement of oncology drugs, for example, influences the decision of which chemotherapy to use for cancer patients.⁶² 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

The Palliative Care initiative 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. Additionally, the California Association of Health Facilities (CAHF) has worked closely with the CCCC to educate skilled nursing providers and other long-term care facilities on the use of POLST, and the other tools that are available to assist with advanced care planning such as INTERACT III and the CARE Recommendations for end of life.

The Palliative Care Action Community, convened by the California HealthCare Foundation, strives to advance the availability of community-based palliative care in California.⁶³ Across California, there are 525 licensed hospice agencies that deliver services through hospital outpatient services, and community-based programming operated by home care agencies.⁶⁴

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 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.⁶⁵ 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.⁶⁶

With respect to the third area of concern, 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.⁶⁷

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 major stakeholders' position on the coverage of providing concurrent palliative and curative care.⁶⁸ In Fall 2013, the California HealthCare Foundation brought together the major insurers in the state to discuss this topic further.

4. Objectives and Targets

Expert stakeholders identified two objectives for the Palliative Care initiative:

- *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 action steps are included in the Innovation Plan.

a) Health Homes for Complex Patients Initiative will incorporate palliative care services.

Because the Health Homes for Complex Patients initiative 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 the Coordinated Care Initiative. 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 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 convened major insurers in the state to discuss a better benefit model for palliative care, including opportunities to redesign oncology reimbursement. In conjunction with the Innovation Plan 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 Innovation Plan's training activities is on the current workforce. As the centerpiece of the Innovation Plan, 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 will seek 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 was successful in obtaining a Medi-Cal waiver to allow concurrent care for children, and, 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.⁶⁹ The state team will also review the recent CMMI funding opportunity regarding the Medicare Care Choices Model.

6. Use of Testing Funds

If awarded, CalSIM testing funds will be used for the following activities:

- Support the joint planning of palliative care and clinical care experts to ensure palliative care services are included within or coordinated with Health Homes for Complex Patients.
- Ensure that palliative care candidate patient identification is included in the Health Homes for Complex Patients initiative.
- Train frontline workers and providers.
- Develop an application for the Medicare waiver or facilitate application for the recent CMMI funding opportunity as appropriate.
- Provide technical expertise, including convening 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 (ACC) Initiative will support the development of two or three 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 will include a Wellness Trust, which will serve as a vehicle to pool and leverage funding from a variety of sources for long-term sustainability.

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.⁷⁰ Historically, however, population health efforts, which involve public health and 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. People who live in low-income communities, in particular, often need more than medical services to improve their health, including supportive community environments to enable and encourage healthy choices and behaviors.

A relatively recent innovation to improve population health and health care is the creation of an ACC.⁷¹ An ACC is a multi-institutional collaborative that brings together the health care sector,

government, non-profit and private sectors, including community organizations, which establishes a 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.

Key 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;⁷²
- 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;⁷³
- 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 will likely choose to focus on a single condition, 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.

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

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 received a White House Champions for Change award,^{74,75} 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, and Washington, as well as through the literature.⁷⁶ 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 diabetic 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. Other communities similarly have many of the necessary building blocks in place that could be well positioned for the pilot.

In addition, many California counties received Community Transformation Grants from the Public Health and Prevention Fund. These grants supported the development of collaboratives designed to address chronic disease through community-based prevention efforts and chronic disease management.

In many of the CTG sites, public health departments 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. In addition, in 12 counties – so-called CA4Health counties – 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, and 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 Innovation Plan grant money for establishment of the ACC and the Wellness Trust. Given the short duration of the grant, California has already embarked upon some “pre due diligence” to enable the selection process to commence immediately upon award of the grant. To date, a work group has developed draft selection criteria, which address:

- Collaboration and partnerships, including the presence of integrated or coordinated systems of care
- Structure and process, including qualities of a backbone organization
- Leadership and support among the various agencies and health care entities
- Geography and reach, including the presence of health disparities

The criteria are designed to establish a high level of readiness and capacity of potential sites, such that the planning time required will be minimized. Moreover, the work group has

identified benchmarks to assess progress of an ACC with regard to outcomes, structure and process, and financing.

Further analysis is being conducted regarding the nexus between secondary and primary prevention, out of recognition of the importance of achieving an ROI within the three year time frame and the need to put into place a pathway for interventions that may take a longer period of time to realize savings; data sharing needs and capacities; and governance models and structures for the Wellness Trust.

b) ACC pilots will create Wellness Trusts and identify sustainable financing mechanisms.

While communities will receive up-front funding for the establishment of the ACC and Wellness Trust, pilots 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 between 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 defined number of community population health outcomes to assess progress and performance. Communities should select appropriate indicators from LGHC Task Force⁷⁷ or from Health in All Policies.⁷⁸ 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, public health, 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

If awarded, CalSIM testing funds will support:

- State activities regarding the selection of sites, implementation, and oversight.

- Start-up funding to develop the infrastructure, incent further collaboration among partners, and seed the Wellness Trust to leverage ongoing resources for ongoing sustainability.
- Technical assistance and cross-site learning.

IV. Building Blocks to Enhance Initiatives and Promote Systemwide Accountability

In order to advance the four initiatives over the short, as well as the longer-term transformation process, the Innovation Plan 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 Cost and Quality Reporting System, Public Reporting, and the Payment Reform Innovation Incubator—are designed to enhance systemwide 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 (OPA), for example, publicizes quality and patient experience information on managed care plans and medical groups. The Office of Statewide Health Planning and Development (OSHPD) produces reports on outcomes for hospitals. The nonprofit Integrated Healthcare Association (IHA) 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 2014.⁷⁹ 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.⁸⁰ 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.⁸¹ 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.

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.⁸²

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.

As part of the planning process for the Innovation Plan, a scan on community health workers (CHWs) was conducted to identify best practices and financing and reimbursement models, and to make recommendations for how such frontline workers could best be utilized within the proposed initiatives.⁸³

2. Current Activities Underway

There are several organizations and efforts related to community health workers and promotores with a long history in California. For example, Latino Health Access in Orange County operates several promotores programs and offers trainings across the state. Visión y Compromiso, established in 2000, provides training, leadership and ongoing advocacy and support to promotores and community health workers and has developed a Network of Promotores and Community Health Workers to develop multi-disciplinary training curricula and coordinate statewide initiatives. Innovative health plans and clinics employ promotores and community health workers to both help individuals with complex medical conditions manage their care as well as help connect care with community issues, such as housing conditions which can trigger asthma.

The California Health Workforce Alliance, a public-private partnership dedicated to developing transformational strategies to meet California's emerging health workforce needs, has identified community health workers as a critical strategy. It recently released a report, "Taking Innovation to Scale: Community Health Workers, Promotores and the Triple Aim."⁸⁴ The report recognized that California CHWs and promotores have the ability to provide models of primary care and needed health interventions for communities, but concludes that much more needs to be done in order to enhance their integration with and in the health care system.

More broadly, there are several state plans for addressing health workforce issues 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 Innovation Plan 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.

3. 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 Innovation Plan. Therefore, the Innovation Plan'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 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.

4. 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 promotores, play critical roles in team-based primary care and represent a key strategy for both enhancing overall capacity of the health workforce and augmenting 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 the needed services for complex patients are non-medical in nature and frontline workers are best suited to address these needs.⁸⁵ Further, frontline workers often are drawn from the communities they serve, allowing for enhanced cultural engagement with respect to patient services.⁸⁶ The Health Homes for Complex Patients initiative also requests that payers create financial incentives for providers to employ cost-effective technologies, such as telehealth, which will help alleviate the uneven distribution of specialty care.

Similarly, for Palliative Care, 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.⁸⁷ 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.⁸⁸ As members of a health care team, 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.⁸⁹

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, and bridging between the health care system and community and social services. Finally, community health workers can help advocate for community health needs and priorities. 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 including palliative care services 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.

In March 2013, The California Endowment announced its commitment to provide OSHPD \$52 million⁹⁰ 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 enhancing cultural competency and diversity of health providers. Among other things, some funds will be used to support health professions training programs that:

- Support 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 CalSIM initiative to identify optimal locations for health homes for complex patients in order to maximize the use of both The California Endowment and CalSIM 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 enhance 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. The Maternity Care initiative, for example, will link with several efforts underway to help providers continually improve, 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 Innovation Plan 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 physicians, nurses, social workers, and frontline workers, such as community health outreach workers. A train-the-trainer model will be explored.

5. Use of CalSIM Testing Funds

If awarded, 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 promotores organizations on how to effectively incorporate them into health care settings. Currently, California does not have any policies in place with regard to reimbursement and compensation, employment, or certification of such workers. There are several models that other states have utilized, many of which require some form of certification.⁹¹ However, certification is a complex and controversial subject among 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 recently formed a workforce work group that includes community health worker leaders from across the state, as well as with other health care professionals, and 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 both the public and private sectors 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 Innovation Plan. 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.⁹² Moreover, California continues to demonstrate innovative ways to advance HIT/HIE within both the public and private sectors.

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.⁹³ 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.⁹⁴ Additionally, a survey performed by the 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).

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) Provider Technical Assistance from the DHCS Medi-Cal EHR Incentive Program –

Although the Regional Extension Centers (RECs) in California had funding discontinued from ONC for support of providers in the incentive program in early 2014, many more California professionals will require significant assistance for Adoption/Implementation/Upgrades (AIU) of EHRs, as well as for Stages 1, 2 and 3 of Meaningful Use (MU). The targeted provider communities of the RECs did not include large provider groups or specialty professionals. Medi-Cal eligible providers will need education and technical assistance to successfully meet AIU and MU objectives and to maximize incentive funding. DHCS has received approval from CMS to administer a technical assistance program for providers through a Request for Proposal process that will provide assistance similar to that which has been received through the REC programs in California. The program includes an anticipated cost of approximately \$37,500,000 in 2014 with \$5,000 for support of each of the 7,500 professionals expected to participate in this program.

(2) 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.

(3) 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.

(4) A partnership between the Integrated Healthcare Association (IHA) and CalOHII to demonstrate a health plan use case for HIE is underway. 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.

(5) 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.

(6) 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.

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 are targeted and designed to specifically support the delineated Innovation Plan initiatives.

4. Action Steps

a) The state will identify best practices for HIE to support care coordination and develop tool kits to facilitate use of HIE. In order to provide patient-centered coordinated care, a health home will require robust EHR/HIE capabilities. This activity will identify health homes that are maximizing the use of EHR/HIE capabilities with a focus on those supporting health homes for complex patients. Based on best practices and lessons learned throughout the state, tool kits will be developed that assist health homes and HIEs in practice transformation initiatives. These initiatives will assist providers' specific use of technology for medical home modeling and will be of particular importance in areas where providers currently accept fee-for-service reimbursement and in underserved areas with complex patients.

b) The state will develop and promote third-party business case analyses of how technologies can produce savings. 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 ensuring data –comparable to fee-for-service data –can continue to be collected 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

If awarded, CalSIM testing funds will support:

- Identification of best practices throughout the state in which EHRs and HIE are being leveraged to achieve the triple aim in the context of care coordination.
- Development of 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.
- Development of business case analyses as well as the data collection report, which will be disseminated, as appropriate, to purchasers, plans and providers.

C. Enabling Authorities Building Block

The majority of initiatives proposed in this Innovation Plan build off existing 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 Innovation Plan, 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. At this time, four potential policy issues are being reviewed for further action.

1. Health Homes for Complex Patients

A key element of the Health Homes for Complex Patients initiative is to take advantage of Section 2703 of the Affordable Care Act. Assembly Bill 361 was signed into law on October 8, 2013, which 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. A federal waiver or State Plan Amendment will be pursued as needed.

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 allowing patients eligible for hospice care to receive all Medicare services during the same period of time in which they receive hospice care. Review of CMMI’s recent funding opportunity is underway.

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.⁹⁵ 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. Discussions are underway with CMS and other states. This rule could also be particularly helpful for the ACCs to be able to more fully utilize community health workers.

4. Cost and Quality Reporting System

As described below, there may be a need for legislative or regulatory activity related to the development of a robust cost and quality reporting system. Legislation can increase the number of providers and payers submitting data into the system, as well as the probability of ensuring levels of accuracy/validity, as evidenced by other states, and afford liability protections. Thirteen states have All Payer Claims Databases (APCDs);⁹⁶ three states are in the process of implementing them, and thirteen others have demonstrated strong interest in implementing such systems.⁹⁷ Given California’s managed care penetration and heavy use of encounter versus claims data, it is unclear whether an APCD is the right approach and additional options are being explored.

D. Cost and Quality Reporting System Building Block

1. Background

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 and improve population health. As consumers face higher deductibles and coinsurance/copayments, they will need to be better equipped to shop for services using comparable information on health plan and provider performance, cost, and outcomes. Representatives of consumer organizations are interested in evaluating the value of narrow networks in the state exchange.

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 toward select procedures.^{98,99} Finally, policymakers need comprehensive data on disease incidence, treatment costs, and outcomes.¹⁰⁰ California needs regional cost information for target setting. Delivery system cost data can begin to tease out whether variation is attributable to cost shifting, community benefits, market clout, etc.

Complete and integrated data that supports comprehensive analysis and comparisons of outcomes across populations, providers, and regions of the state could be housed in a cost and quality reporting system database. This system 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. 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 stakeholders to better gauge the extent to which fee-for-service payments are shifting toward value-based payments.

2. LGHC Goals

A cost and quality reporting system 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.¹⁰¹ CHPI also collects data from the California Public Employees' Retirement System (CalPERS), the largest employer purchaser of health benefits in California and the second largest in the nation.¹⁰² A multi-stakeholder board that represents health plans, purchasers, consumers, and providers governs CHPI.¹⁰³

For many years the Integrated Healthcare Association has worked with health plan and provider managed care data to measure metrics for its Pay for Performance program. More recently IHA developed a physician organization level total cost of care metric. IHA is working with encounter and claims data to produce more refined value measures of cost and quality.

4. Objectives and Targets

The key objective for this building block is to create a cost and quality reporting system in order to expand analyses for performance measurement and public reporting.

5. Action Steps

At this time the state is pursuing two avenues: (1) conducting conversations with stakeholders about the pros and cons of an APCD and soliciting other options for producing needed data/information; and (2) developing a proof of concept project to demonstrate cost transparency within regions and top episodes of care. More tangible action steps will follow based once a clear path has been determined.

6. Use of Federal Testing Funds

A California HealthCare Foundation report estimates that the annual maintenance cost for an APCD in California would run between \$1.5 and \$4.7 million.¹⁰⁴ The cost of maintaining a cost and quality reporting system 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.¹⁰⁵

Testing funds would be used to expand or start up a database, as well as to conduct analyses to complete the Innovation Plan 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 Innovation Plan. Throughout the proposed initiatives, public reporting plays a fundamental role. Currently, 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.¹⁰⁶ The State of California would like to build off of OPA's current work to provide public reporting on 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.

4. Action Steps

The OPA or an equivalent state department will be the home for a dynamic LGHC and Innovation Plan 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. CHHS is committed to building and growing a comprehensive, consumer-friendly website that incorporates existing and expanded performance metrics related to LGHC and the Innovation Plan, as appropriate.

5. Use of Federal Testing Funds

Federal testing funds would be used to advance the development of a 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 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 Innovation Plan will build on this key asset by supporting IHA to explicitly

serve as a forum or incubator for system-wide payment reform activities. There are other organizations in the state that do this type of work as well, and partnerships with them may be developed as is needed. In addition, IHA would support select Innovation Plan 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 and develop methodologies to measure the Innovation Plan goals of reducing fee-for-service payments and reforming payments that reward performance and value in partnership with researchers at the University of California, Berkeley.

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 Innovation Plan 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.
- Partner support, as needed.

V. Financial Analysis

This section of the Innovation Plan 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, and, therefore, are not at sufficient scale to calculate savings. Nevertheless, it is anticipated that they will achieve a return on investment as well.

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:

$$[\text{Total Savings}] = [\text{Target Population}] * [\text{Engagement Rate}] * [\text{Savings Per Member Per Year}]$$

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).¹⁰⁷ 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 Innovation Plan initiatives are between \$1.4 and \$1.8 billion over three years (**Table V.1**). Much of the estimated savings detailed below is due to cost avoidance. 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	\$1,140M	\$1,491M
Maternity Care	\$76M	\$160M
Palliative Care	\$145M	\$195M
Total	\$1,361M	\$1,846M

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 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 cost and quality reporting system will collect vital information 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 Innovation Plan, has the potential to affect 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**.

C. Maternity Care Initiative

Over the three year period, Maternity Care innovations are estimated to save California \$76 million to \$160 million – up to \$124 million for Medi-Cal and up to \$36 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	NA	\$48-124 M	\$14-36 M	\$76-160 M

D. Health Homes for Complex Patients Initiative

Over the three-year period, Health Homes for Complex Patients are estimated to save California up to \$1.5 billion – including \$1.3 billion for Medicare, \$154 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 are net savings, reflecting savings less the costs of providing health home services.

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, 290 M	\$118-154 M	\$36-47 M	\$1,140-1,491 M

E. Palliative Care Initiative

Over the three-year testing period, the Palliative Care initiative 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 intentionally left blank.

VI. Conclusion

When the Let's Get Health California report was issued in December of 2012, it was intended to launch efforts across the state in support of the vision of California becoming the 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, reforming financing, and respecting patient preferences for care options – these activities will lower costs while improving health outcomes. Moreover, by

targeting high cost patients, the Innovation Plan is expected to produce significant savings – \$1.4 billion to \$1.8 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 Innovation Plan 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 Innovation Plan, has laid the groundwork for the kinds of collaborations needed to implement this multi-payer plan. The Innovation Plan is a rare opportunity to catalyze lasting change. By leveraging the momentum of dozens of innovative health system reform efforts already underway, the Innovation Plan will catalyze further progress and accelerate the spread of both delivery system and payment reforms.

Endnotes

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