State Innovation Model Update

Presentation to the Healthcare Cabinet

November 10, 2015

Topics to Cover

1. Health Care Payment Learning & Action Network (HCPLAN) Summit: the national landscape of healthcare reform
2. SIM Consumer Engagement Efforts Launched

1. **Health Care Payment Learning & Action Network (HCPLAN) Summit: the national landscape of healthcare reform**

Medicare has set ambitious goals for value-driven care

CMS support of health care Delivery System Reform will result in better care, smarter spending, and healthier people by focusing on the way we pay providers, deliver care, and distribute information

Public and Private sectors

Key characteristics

- Producer-centered
- Incentives for volume
- Unsustainable
- Fragmented Care

Systems and Policies

- Fee-For-Service Payment Systems

Key characteristics

- Patient-centered
- Incentives for outcomes
- Sustainable
- Coordinated care

Systems and Policies

- Value-based purchasing
- Accountable Care Organizations
- Episode-based payments
- Medical Homes
- Quality/cost transparency

Health Care Payment Learning & Action Network

- CMS: "**Medicare alone cannot drive sustained progress** towards alternative payment models"

- "Success depends on a **critical mass of partners** adopting new models"

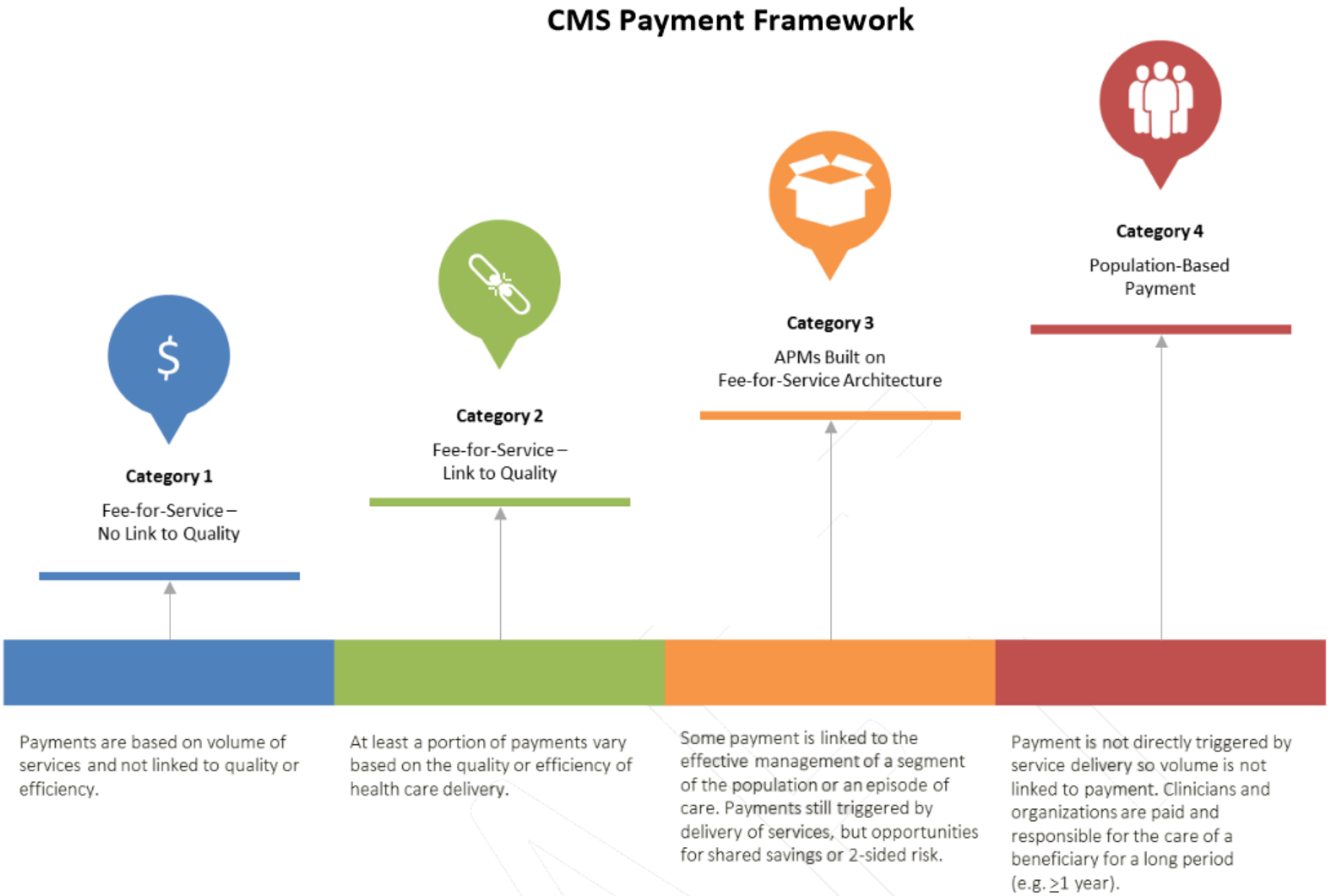
- The Department of Health and Human Services (HHS) is working in concert with stakeholders in the private, public, and non-profit sectors to transform the nation's health system to emphasize value over volume. To support these efforts, HHS has launched the **Health Care Payment Learning and Action Network** (HCP LAN) to help advance the work being done across sectors to increase the adoption of value-based

HCP LAN
Health Care Payment Learning & Action Network

Health Care Payment Learning & Action Network

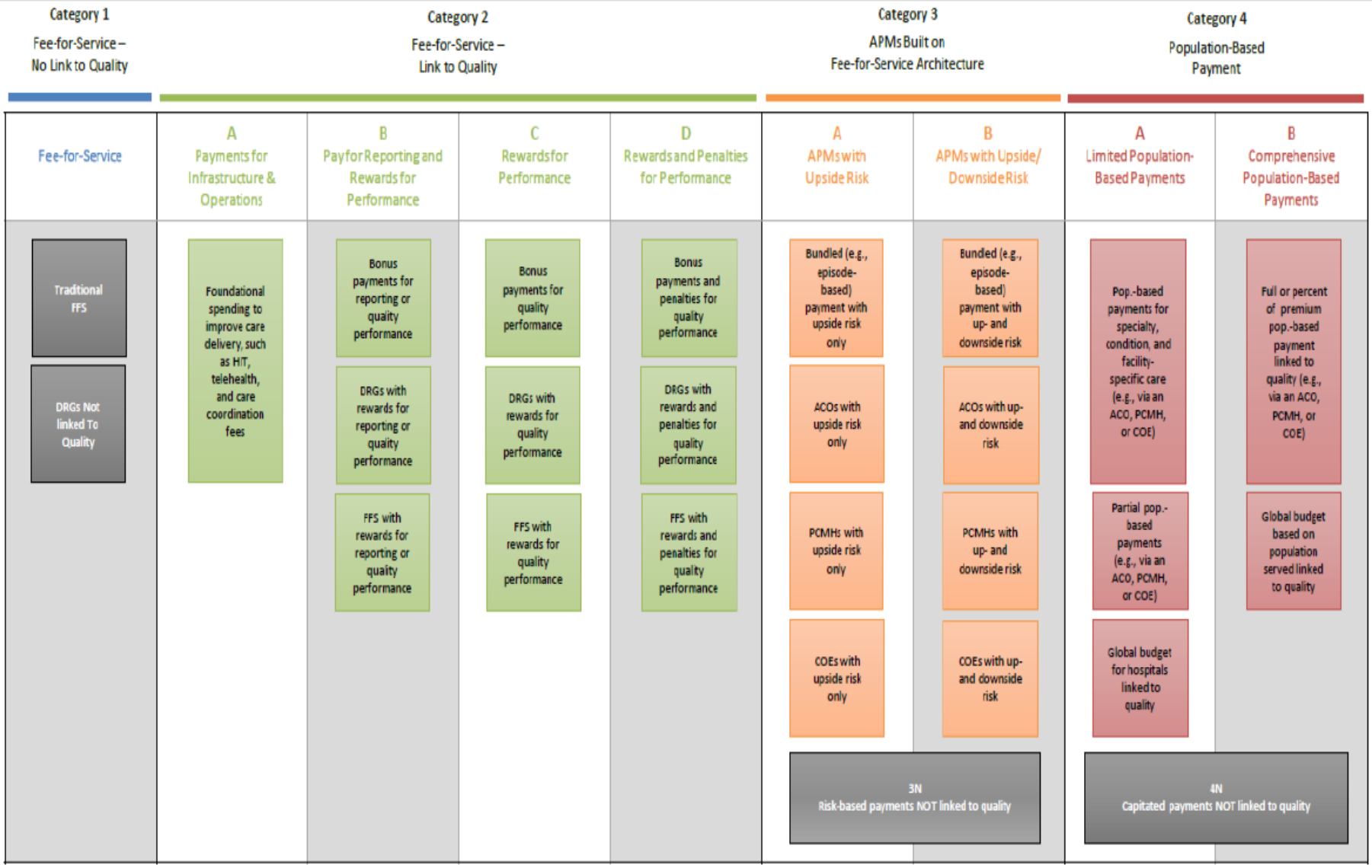
- **Define terms and concepts** associated with alternative payments
- HCP LAN will drive **agreement, adoption, and action** among stakeholders
- Share **best practices, early results, and learning**
- Establish a **framework** and measure progress towards goals of increasing U.S. health care payments linked to quality and value

What is an Alternative Payment Model (APM)?



HCP LAN APM Framework

Draft LAN Framework



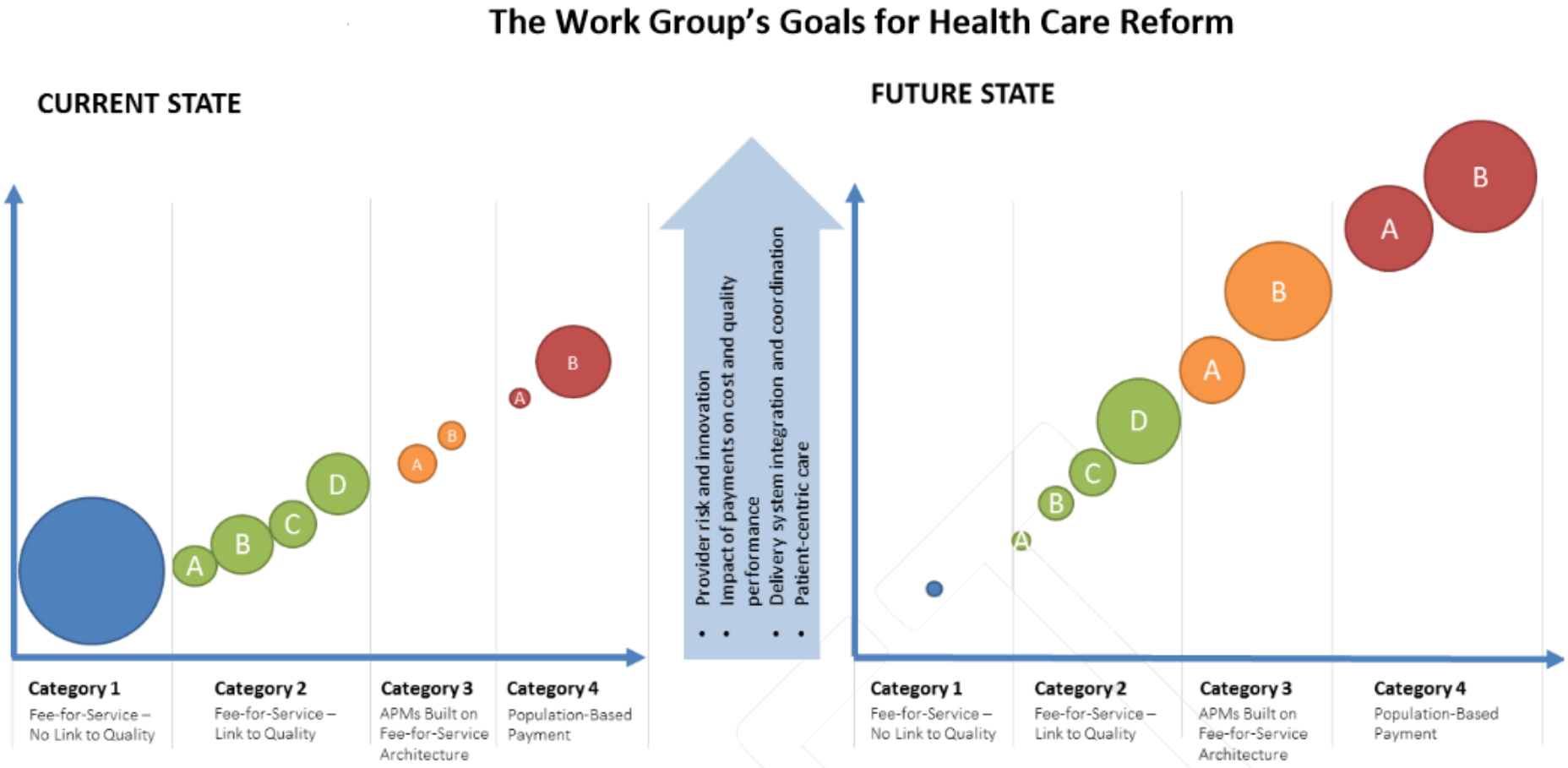
Alternative Payment Framework

CMS has adopted a framework that categorizes payments to providers

Historical state → Evolving future state

	Category 1: Fee for Service – No Link to Value	Category 2: Fee for Service – Link to Quality	Category 3: Alternative Payment Models Built on Fee-for-Service Architecture	Category 4: Population-Based Payment
Description	▪ Payments are based on volume of services and not linked to quality or efficiency	▪ At least a portion of payments vary based on the quality or efficiency of health care delivery	▪ Some payment is linked to the effective management of a population or an episode of care ▪ Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk	▪ Payment is not directly triggered by service delivery so volume is not linked to payment ▪ Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g., ≥1 year)
Medicare Fee-for-Service examples	▪ Limited in Medicare fee-for-service ▪ Majority of Medicare payments now are linked to quality	▪ Hospital value-based purchasing ▪ Physician Value Modifier ▪ Readmissions / Hospital Acquired Condition Reduction Program	▪ Accountable Care Organizations ▪ Medical homes ▪ Bundled payments ▪ Comprehensive Primary Care initiative ▪ Comprehensive ESRD ▪ Medicare-Medicaid Financial Alignment Initiative Fee-For-Service Model	▪ Eligible Pioneer Accountable Care Organizations in years 3-5 ▪ Maryland hospitals

Future State of APM Adoption



The overarching objective of the LAN is to encourage alignment between and within the public and private sectors as the health care system moves away from traditional fee-for-service payment. The LAN recommends that, over time, public and private health plans should move concertedly towards **APMs in Categories 3 and 4,** to achieve the goals of healthier people, improved care, and reduced cost

Goals for Medicare's value-based payments

During January 2015, HHS announced goals for value-based payments within the Medicare FFS system

Medicare Fee-for-Service

GOAL 1: **30%**

Medicare payments are tied to quality or value through **alternative payment models (categories 3-4)** by the end of 2016, and 50% by the end of 2018

GOAL 2: **85%**

Medicare fee-for-service payments are **tied to quality or value (categories 2-4)** by the end of 2016, and 90% by the end of 2018

STAKEHOLDERS:

Consumers | Businesses
Payers | Providers
State Partners

Set **internal goals** for HHS

Invite **private sector payers** to match or exceeed HHS goals

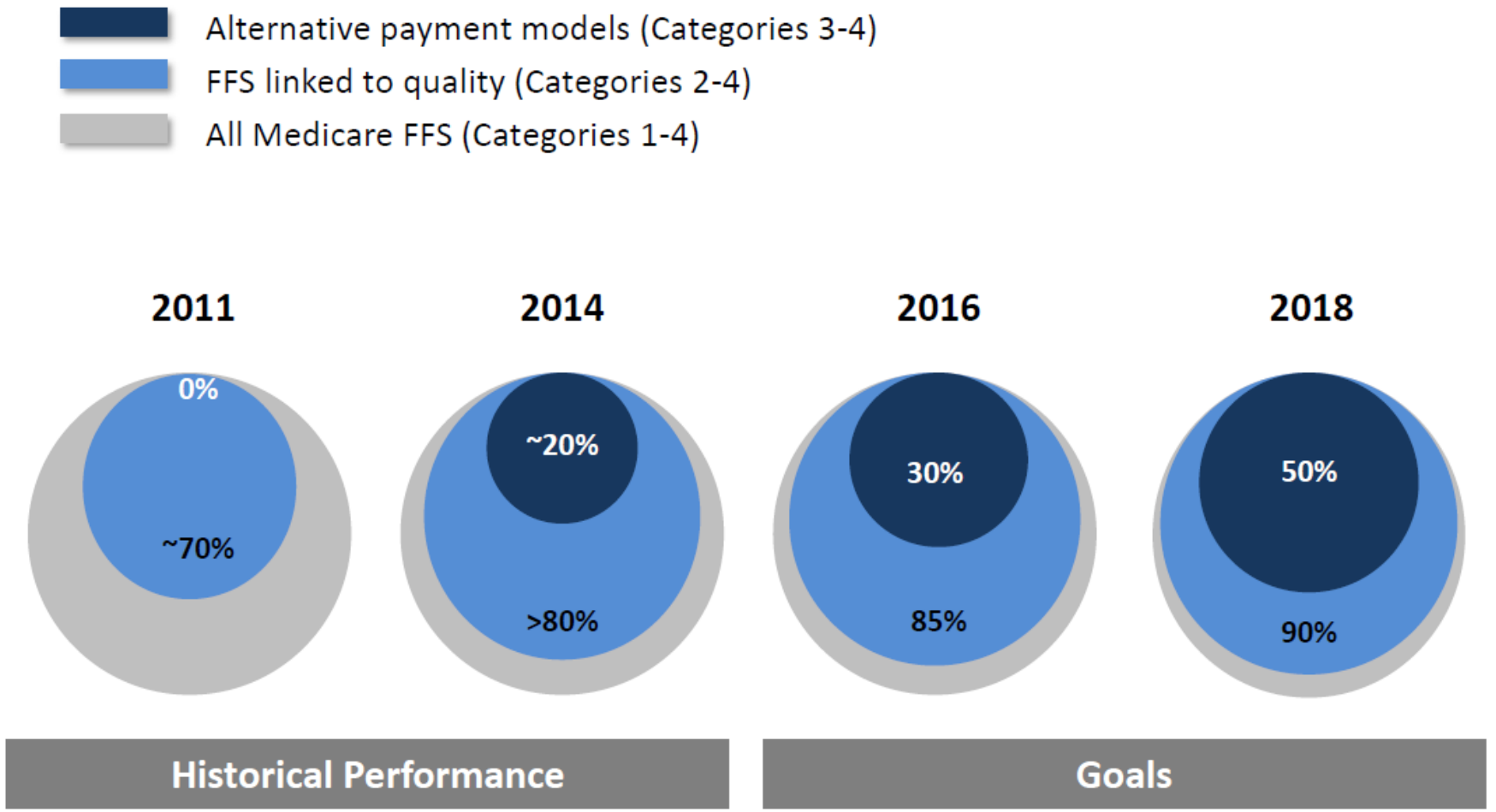
NEXT STEPS:

Testing of new models and expansion of existing models will be critical to reaching incentive goals

Creation of a Health Care Payment **Learning and Action Network** to align incentives for payers

National Goals for Medicare

Target percentage of payments in 'FFS linked to quality' and 'alternative payment models' by 2016 and 2018



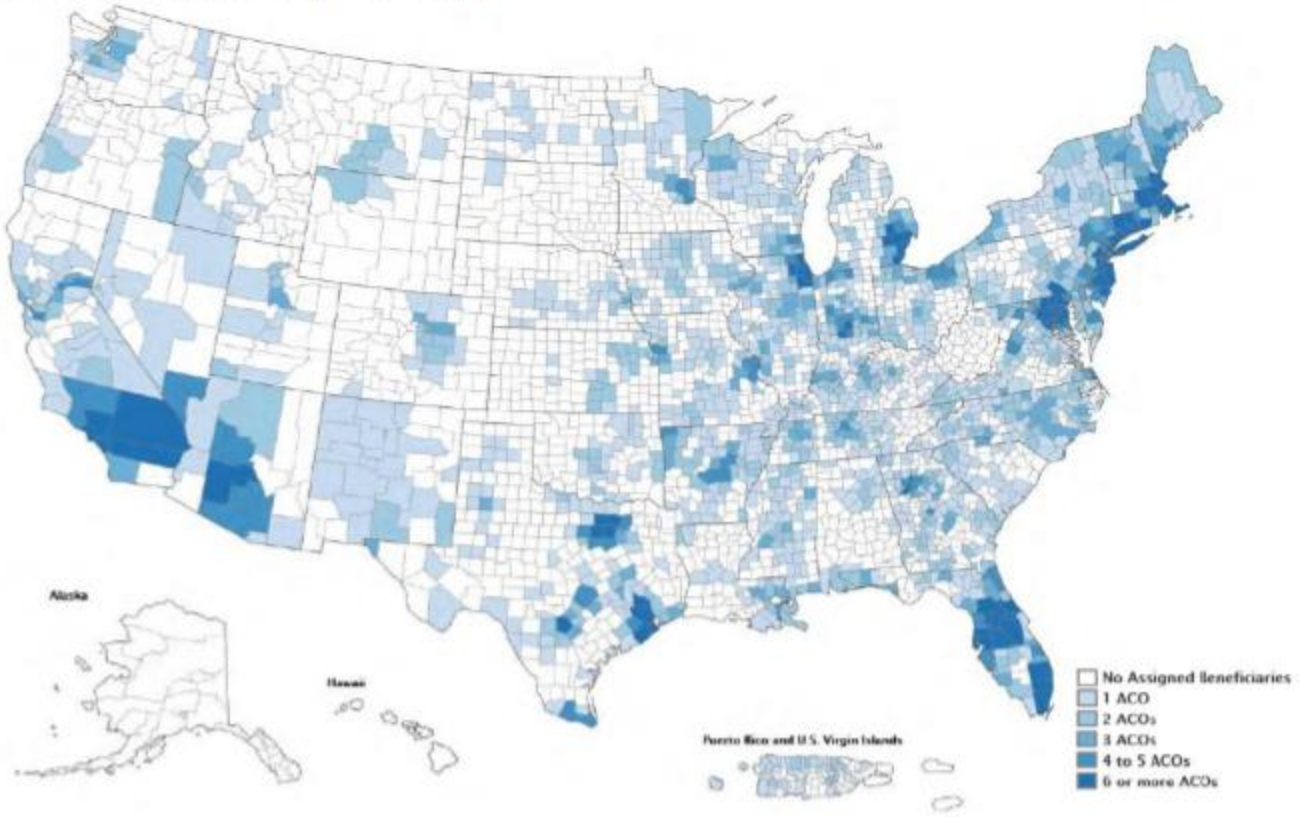
HCP LAN U.S. Health Care Goals

- Match or exceed Medicare alternative payment model goals across the US health system (Medicaid, Medicare, commercial):
  - **30% in APM by 2016**
  - **50% in APM by 2018**
- Shift momentum from CMS to private payer/purchaser and state communities
- Align on core aspects of alternative payment design

Accountable Care Organizations: Participation in Medicare ACOs growing rapidly

- **423 ACOs** have been established in the MSSP and Pioneer ACO programs*
- **7.9 million assigned beneficiaries**
- This includes **89 new ACOS** covering **1.6 million beneficiaries** assigned to the shared saving program in 2015

ACO-Assigned Beneficiaries by County



Connecticut SIM and APMs

- It was emphasized that changing the financial reward for providers is only way to drive sustainable and innovative approaches.

- Empowering consumers and advancing health care delivery capabilities are needed simultaneously.

- The SIM grant is a unique opportunity for states like Connecticut to fund multiple initiatives that reinforce each other in the areas of payment reform, care delivery support, quality measure alignment, consumer engagement, and workforce development.

2. SIM Launches Consumer Engagement Efforts

Engaging Consumers is Critical

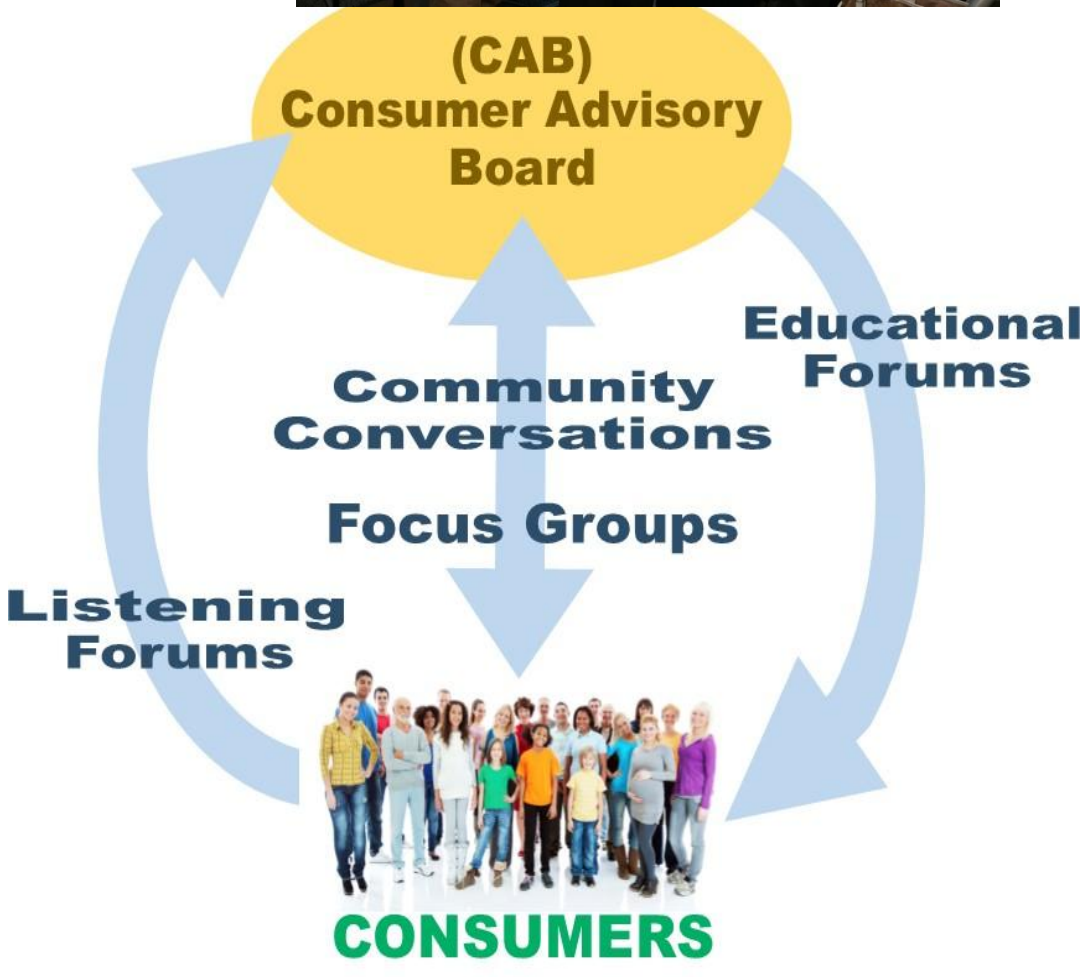
- October marked the beginning of SIM efforts to engage consumers in the implementation phases of the grant

- **As the healthcare system changes, engaging and empowering consumers in their current and future role in the healthcare system is critical**

SIM Consumer Advisory Board

- SIM has a variety of stakeholder and consumer engagement efforts, outlined in our Stakeholder Engagement Plan

- The SIM Consumer Advisory Board's mission is to advocate for and facilitate strong public and consumer input to inform policy and operational decisions on healthcare reform in Connecticut



Rural Healthcare Forum

- Participants brought up barriers such as limited access to behavioral health services, lack of transportation, and workforce shortages. The need to focus on underlying issues like poverty was emphasized by panelists. Telehealth was described as a useful tool to provide care to the rural population. Prevention and consumer engagement were also mentioned as an important pathway to health.

Southeast Asian Listening Session

- Health conditions such as high rates of diabetes and hypertension are highly prevalent in the Southeast Asian community. Additionally, those that fled from the regimes of Khmer Rouge and Pol Pot in the 1970s and 1980s and came to Connecticut have high rates of trauma, depression, and post-traumatic stress disorder. Research shows that if you have post-traumatic stress disorder you are 60% more likely to develop type-two diabetes.