Governors Best Positioned to Improve Health of Residents, Innovate Health Care Delivery and Promote Healthy Living
February 2016

Executive Summary

Recognizing that people-centered care that produces the triple aim of better health, better care and lower costs requires transforming how health care is delivered and providers are paid, the race to alternative payment models is on. In January 2015, the Department of Health and Human Services (HHS) announced its goal of tying 30 percent of Medicare payments to quality and value through alternative payment models by 2016 and 50 percent of payments by 2018. These Federal goals demonstrate the national imperative to address health care costs that account for ever-growing proportions of the Gross Domestic Product (GDP) – all while acknowledging quality performance is lagging in many areas.

Private stakeholders are mirroring the HHS goals to move to value. Members of the Health Care Transformation Task Force (HCTTF) – a national consortium of patients, payers, providers, and purchasers – are committed to placing 75 percent of their respective business operations under value-based payment arrangements by 2020. As a member of the HCTTF, Trinity Health has also adopted this value-based payment goal.

The desire to pay for quality over quantity has existed in the private sector for some time with providers, payers and even large employers—such as IBM and Boeing—leading the way by testing new models of care delivery and value-based payment. These innovations can be scaled and replicated; and, when private partners work with public leaders change can occur quickly.

Here’s the new realization: people-centered care requires more than transforming payment and models of care delivery; it also requires integrating care delivery with community health efforts to build healthier communities. Regional, community health efforts that organically identify opportunities to improve the health of the community—and are planned and governed by regional entities—are critical to long-term transformation success. The payment and delivery reform and community health streams of work must happen in tandem.

Success requires a commitment from—and alignment among—public and private payers, providers, consumers, and Federal and state governments. However, more than any other single stakeholder, Governors have a powerful role to play in building a people-centered system of care. While every state will take a unique approach to reform, the first thing all Governors should do is exercise bold leadership around alternative payment and community health goals, and the process for achieving them. The State Innovation Model (SIM) initiative was intended to help states improve the health of their residents by transforming the delivery of care as well as investing in new approaches to support individuals and communities pursuing healthy living. The grants can help Governors drive collaboration with payers, providers, patients, and many other stakeholders, and may help compel these key actors to the table. Using SIMs or through other reform efforts, Governors should leverage their unique position to:
1. Transform HealthCare Delivery
Convene a multi-segment task force that serves as catalyst for statewide payment and delivery system transformation. Include leaders of the major payers, providers, provider associations, employers and patient advocacy organizations. The goal is to develop and execute key components of a state plan. As an example, payers, providers and employers could agree to develop contractual arrangements similar to the Medicare accountable care organization (ACO) Shared Savings Program (SSP) and the Bundled Payment for Care Improvement (BPCI) Initiative.

2. Promote Healthy Living and Communities
Improving the health and well-being of our communities will require local public health and community development leaders working together to drive innovation. To accomplish this goal, Governors should pull together a broad alliance of stakeholder groups including state, public health, community agencies, consumer representatives and patients. Many of these entities are already working on specific areas, but typically they are underfunded and disconnected from the larger and better financed health-care system.

3. Drive multi-payer, collaborative learning across states
The Center for Medicare and Medicaid Innovation (CMMI) SIM initiative presents an unprecedented opportunity to improve population health; integrate public health, community resources and the health care delivery system; address workforce and information technology needs; and reduce long-term health risks for people, particularly high-need populations. The SIM initiative offers states important financial and technical support to drive multi-payer, provider and community stakeholder innovation and change on a new scale. SIM participants should share their early experience and learnings with one another.

Governors in states already receiving SIM awards have an advantage with funding and technical support. The SIM initiative provides scaffolding for their visions. Governors in SIM states should be leading the nation in delivery and payment innovation as well as building healthy communities. In five years, these will be the states with transformative, sustainable and replicable models.

Background
Health care in the U.S. has historically been characterized by fragmented care delivery, with little coordination across siloed providers and sites of care. This care delivery approach results from a Fee-for-Service (FFS) payment system that rewards fragments of care, not coordinated high-value care. The results have been unsustainable rising costs and low-value care for patients. Health care spending as a share of the GDP was 5 percent in 1960, but is projected to reach nearly 20 percent in 2024.1,2 Despite these high levels of spending, Americans are not consistently receiving high-quality care and rank low in population health status compared to other countries.3 Numerous reports have detailed quality problems and gaps in care. One of the most notable demonstrated that patients in the U.S. only received “recommended care” 55 percent of the time.4 The Affordable Care Act (ACA) is projected to expand coverage to 25 million Americans by 2025 – especially to low- and middle-income Americans, and those who were previously unable to access health insurance coverage due to preexisting conditions and other barriers.5 Those gains, however, will not be sustainable unless we find a way to improve the value of health care by improving efficiency and health outcomes.

Public and community health efforts have historically been charged with improving health outcomes as well. Intended to improve the underlying determinants of health in populations, they have been widely underfunded. They have also been historically unconnected to the much larger health care delivery and financing activities of health care systems and payers. The result of these realities is that we spend much more to treat than to prevent illnesses—to the detriment of the health of our populations.

The ACA included significant provisions to address delivery system reform and to improve public and community health. The law sought to change the FFS payment systems to one based on rewarding providers for delivering high value care. One example is the Medicare Shared Savings Program (MSSP). The law also created the CMMI with unique capabilities to test new payment models and potentially make them national programs if they reduced Federal health costs while maintaining or improving quality for beneficiaries. The imperative from lawmakers was clear: transforming the payment and delivery system is the linchpin to affordability and sustainability.

Since the passage of the ACA, the Federal government (mainly through Medicare), states, commercial payers and providers are testing and implementing new payment models to move away from FFS to payment based on the value of services provided. The Centers for Medicare and Medicaid (CMS) is leading many efforts, with some new models being permanent (e.g. MSSP), while other models are being tested through CMMI – such as the Comprehensive Primary Care Model. Providers are participating in and developing many of the new delivery models that are targeted on improving the quality and efficiency of care. While value-based payments have been tested in the past, broad-based innovation and transformation of payment and delivery systems has not occurred because initiatives have been of limited scope—usually involving a single payer and provider. Such approaches typically do not provide sufficient reason for the parties to fundamentally change the way care is financed and delivered. Most observers believe that to get real transformation of care delivery we will need to involve multiple payers and providers in a region.

The ACA also included significant investments in public and community health including the Prevention and Public Health Fund (Section 4002), which was originally appropriated $15 billion. The intent was to create new approaches to improving preventive health and the underlying determinants of health for populations. As noted above, however, these initiatives were not directly connected to delivery system innovations. This continuing siloed approach—where public and community health activities are separated from delivery innovation—appears to many to be a missed opportunity to obtain important synergies from both approaches that could help optimize the health of our populations and improve the overall cost of health care.

At the time of ACA passage, there was growing thought that states are best positioned to bring these activities together. This thought was based on the understanding that Governors are the only elected officials with access to practically all parts of the health care ecosystem. Typically they are the largest purchasers of health care services in their states through their Medicaid and State Employee Benefit programs. Reconfiguring entrenched payment systems and incentives across broad segments of the health care system is essential to ensure that real change occurs. When Medicaid and other state programs are coupled with existing Medicare, Medicare Advantage and commercial insurers to drive alternative payment models – total system transformation is possible. Their regulatory powers also position state leaders to work closely with and regulate commercial payers and providers. Not only does state government have the potential for driving significant change in health care financing and delivery, but it also has the ability to align those efforts in ways that create synergy with the broader context of the states’ needs and development across economic, education and other domains of well-being. Whether through regulations around housing, licensing or public health agencies, Governors have visibility into—and the ability to impact—the full range of health and welfare issues in their states. Finally, Governors tend to be innovators.

Commercial carriers and Medicare are testing a number of reforms including ACOs, Primary Care Medical Homes (PCMHs), and episode-based payments. Each of these is intended to drive fundamental change in the way care is delivered and reimbursed. Momentum toward broad-based delivery system transformation is building. However,
to date, these activities are affecting only a limited set of providers, and only portions of their patient population. In order to achieve the transformation tipping point, Medicaid and state employee populations should be included in this innovation. Once these populations are included, the bold alternative payment goals envisioned by many will be attainable.

**The SIM – A Test of the State as the Best Place to Optimize Health**

The SIM was created by CMMI to test the belief that the most robust approach to improving health care delivery and population health is through state government.

In August 2012, CMMI released a Funding Opportunity Announcement (FOA) for the SIM initiative. This initiative explicitly was intended to test the theory that states—led by their Governors—are in a strong position to use the broad array of levers at their disposal to eliminate silos by bringing together the delivery and payment system with community health activities.

CMMI seeded state engagement in system transformation with two rounds of SIM grants to support the development and implementation of State Health Care Innovation Plans. The plans are intended to drive delivery system innovations as well as new approaches to support healthy living for state residents. Awards have included design, pretesting and testing and were awarded based upon each state’s stage of development. Over the past three years, 35 states and Washington, D.C. have received some form of SIM grant totaling almost $1 B. Seventeen have received the most advanced testing grants. In addition to grant funding, states receive technical support and are encouraged to apply for waivers allowing greater flexibility and true innovation.

**Considerations for Implementation**

Achieving the aims of the SIM to transform the payment and delivery models of care delivery and to integrate care delivery with community health efforts to build healthier communities is certainly an ambitious, even audacious goal. We believe it is best to start by recognizing that while theses two aims are related, the required work differs significantly along the following key dimensions:

1. The parties needed to be involved
2. The variety of alternative paths to be pursued
3. The activities that need to be pursued
4. The ability to fund the interventions
5. The milestones along the way
6. The definition of success
7. The timeframe for measuring success
<table>
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<tr>
<th><strong>Key Dimension</strong></th>
<th><strong>Health Care System Payment &amp; Delivery Reform</strong></th>
<th><strong>Building Healthier Communities</strong></th>
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<tr>
<td><strong>Parties Involved</strong></td>
<td>Governor’s Office, major provider systems, physicians groups, payers, large employers, consumer advocates – in most states this could amount to fewer than 20 leaders at the table. Governors are critical to ensuring relevant parties participate.</td>
<td>Same parties plus representatives of state public health, Medicaid, social services, transportation, recreation, and housing agencies; in addition to local public health, community based agencies, social service providers, economic developers, employers, labor unions, clinicians and consumers.</td>
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<td><strong>Variety of Paths to Pursue</strong></td>
<td>Alternative Payment Models include: ACOs, Shared Savings, PCMH, and Episode Based Payments.</td>
<td>Wide variety of approaches cutting across community activities: housing, food availability, ethnic disparities, types of communities. Community health workers are critical to success.</td>
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<td><strong>Key Activities</strong></td>
<td>Tracking the development and growth of alternative payment contracting, and designing and implementing new care models.</td>
<td>Broad stakeholder engagement to further population health activities driven at the community level and integration of primary care delivery with community support services that address social determinates of health and behavioral health.</td>
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<td><strong>Funding Sources</strong></td>
<td>Ample funding in existing system but need agreement on how to redistribute.</td>
<td>Savings and efficiencies created with regional collaboration; hospitals to engage as critical funding partners, economic development entities to engage, and other new sources. Funding likely.</td>
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<td><strong>Geographic Scope</strong></td>
<td>Statewide approach acknowledges common payers, large provider networks or health systems, state as payer for Medicaid and state employees across all regions.</td>
<td>Regional approach allows for large scale community based initiatives.</td>
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| **Mile Stones** | Progress of agreement on contracting models; evidence of implementation of new care delivery models; number of individuals covered under the new models; percentage of all health care payments and revenue driven by new models. | Community health deficits addressed with new community based coordination and programs including: transparent and coordinated community health metrics.  
  - Expansion of technology to support care processes.  
  - Transparent and consistent quality reporting.  
  - Enhancements to primary care workforce.  
  - Access to predictive analytics.  
  - Comprehensive community intervention database. |
| **Definition of Success** | Triple Aim outcomes:  
  - Better Health Outcomes – HEDIS metrics and others  
  - Better Care Experience – patient satisfaction surveys  
  - Lower Total Cost of Care – Insurance claims based | Improved Population Health Metrics  
  Improved Underlying Determinants of Health  
  Decreased Disparities in Care and Health Outcomes |
| **Timeframe for Measuring Success** | 1-2 years | 3-7 years |
Governors with State Innovation Model Grants Best Positioned to Achieve People-Centered Care

Implementation

Governors should use their unique positions to accomplish:

1. **Health Care System Payment and Delivery Transformation**

Convene a multi-segment task force that serves as catalyst for statewide payment and delivery system transformation. It would include leaders of the major payers, providers, provider associations, employers and patient advocacy organizations. The goal would be to develop and execute key components of a state plan. As an example: payers, providers and employers could agree to develop contractual arrangement similar to the Medicare SSP ACO Program and the BPCI Initiative. General contract terms and approach would be developed across the state. Specific contract terms would be left to individual parties. Of course modifications could be developed and agreed to by the group. Patient advocates would be involved to provide consumer input on the models. The group could also consider alternative approaches to care delivery under these models. However, given the contract terms, and the differences between provider entities much discretion would be left to the individual parties. Additionally, the group could offer a mechanism of accountability for those involved to ensure that there is good faith work being pursued by all.

The group could also greatly simplify the work for all concerned by agreeing on some common measures of success and outcomes. Selecting a set of triple aim metrics that all agree to use could accelerate the transformation for all. The group could also agree on milestones such as the percentage of the population to be included in these new models, perhaps agree on the sequencing of regional implementation if that makes sense, and obtain commitments from the parties to submit documentation of progress on an ongoing basis.

Ohio Governor John Kasich used this approach in 2013 when he convened, The Advisory Council on Health Care Payment Innovation (Council) – comprised of health care purchasers, providers, plans and consumer advocates – to prioritize and coordinate multi-payer health care payment innovation activities statewide. The Council interacts closely with The Governor’s Office of Health Transformation and its Director Greg Moody. Early on, this group reached agreement on value-based payment goals and strategies and adopted principles from the Catalyst for Payment Reform. Expansion of medical homes and implementation of episode-based payments for acute events are hallmarks of the Council’s work. While the effort to reset market incentives has met challenges; the work is sustained, in part, because of early and important buy-in from payers and providers.

2. **Building Healthier Communities:**

Sustainable transformation requires integrating new care delivery with efforts to build healthier communities. Payment innovation and care delivery reform are only two of the three transformation stool legs. Once aligned around payment and delivery, payers and providers will have more interest in addressing underlying determinants of health. In fact, outcome metrics for various payment models could include community-based improvements. While access to excellent health care can drive improvements in health status, the vast majority of differences in the health status of populations result from differences in healthy living and the underlying social determinants of health. Optimizing health in state populations, therefore, will require a commitment to promoting healthier living and addressing the underlying social determinants of health – including access to transportation, housing and nutritious food. Improving the health and well-being of our communities will require local public health, community agencies, providers, consumers and community development leaders driving innovation at the community level. In many communities, these entities are already collaborating in specific areas, but typically they are underfunded and disconnected from the larger and better financed health care system. While these efforts must be local and organic, statewide coordination and support is important.
One way to accomplish this integration is for the state to develop a public private partnership that includes state agencies, public health, social service agencies, economic development, payers, providers and consumer advocates. Public private entities (nonprofit councils, institutes, and commissions) are regularly used by Governors to advance and implement policy priorities. Coordinated by state government or their delegates, the partnership would ensure coordination with health system payment and delivery reform efforts. This group would address the broader issues of the underlying determinants of health, and integrate regional efforts with health care financing and delivery innovations. This type of public private entity provides insulation from politics and builds momentum that a Governor cannot always create independently. The inclusion of savvy business representatives can also hasten the speed by which the effort moves. The creation of a public private entity staffed by experts also addresses the need for long-term sustainability even after existing grant funding might run out; ultimately providing continuity across multiple state administrations. Finally, this approach allows the important work of transforming payment and care delivery to proceed at its own, presumably faster pace, but ensures deep coordination across the two efforts to obtain synergy.

Outcomes from this work might include:

- Integration of primary care delivery with community support services that address social determinates of health.
- Acceleration of state’s population health priorities (e.g., reduction in obesity, diabetes, teen birth rates, excessive alcohol consumption, tobacco use).
- Integration among primary care and behavioral health.
- Coordination across different health care systems in a community
- Improved attention to the patient as a whole person by health care provider.
- Transparent and coordinated community health metrics.
- Expansion of technology to support care processes.
- Transparent and consistent quality reporting.
- Enhancements to primary care workforce.

An example of a state that has already begun to coordinate payment and delivery reform with community health and wellness is Delaware. Governor Jack Markell set an ambitious “Triple Aim”—to be one of top five healthiest states, be one of top five states in health care quality and patient experience, and reduce the growth of health care costs.

He convened leaders from major provider systems, physicians groups, payers, large employers, state agencies and consumer groups challenging them to develop new payment and care delivery models. As a result of the Governor’s clear vision, Delaware is projected to become the first state to have every hospital in a MSSP. The state leveraged early success of the Delaware Health Information Exchange and a prior CMMI grant to elevate practice transformation. With the desire to address healthy communities, the Delaware Center for Health Innovation was created. This non-profit center is chaired by a business leader and is responsible for improving population health, enhancing care and reducing health care costs across the state. In order to deliver care better, Delaware is putting the final touches on its new simple, common score card of preferred outcomes and measures to be adopted by all payers. It has engaged hundreds of stake-holders. The Delaware Center for Health Innovation work plan includes a robust population health effort centered around a “Healthy Neighborhoods” model which integrates communities with their local care delivery systems. The goal is to build bridges across and among existing efforts. The state has been divided into 10 communities and is projecting significant improvements to maternal and child health, mental health and addiction, chronic disease prevention and management, and healthy lifestyles. While Governor Markell’s office may not be as engaged now as it was at the start, the effort continues to grow as a result of his early, result-driven leadership.
3. Multi-payer, sustainable change learnings across states in coordination with CMMI SIM initiatives

The SIM initiative presents an unprecedented opportunity to improve population health; integrate public health, community resources and the health care delivery system; address workforce and information technology needs; and reduce long-term health risks for people, particularly high-need populations. The CMMI SIM initiative offers states important financial and technical support to drive multi-payer, provider and community stakeholder innovation and change on a new scale. In exchange, SIM states are expected to achieve 80 percent of statewide payments through innovative payment models in five years.

While the SIM program anticipates broad-based changes in community and public-health based efforts, the grant awards made payment and delivery system change a foundational part of every state’s plan. In conjunction with resources available at the state level, the SIM initiative also offers complementary tools and financial resources to further support transformation. For instance, states are using SIM funding for:

- Developing and promoting a consistent, common set of quality and cost measures across all payers.
- Multi-payer payment and delivery reform design (e.g., ACOs, bundling, and medical/health homes).
- Health IT (Health Information Exchanges, interoperability).
- Data warehouses (all-payer claims databases).
- Community health improvements, including a focus on transforming communities through regional collaboratives to reduce avoidable disparities and promote health.
- Consulting support (e.g., to leverage learnings from other states, payers and providers).

States also have the opportunity to work directly with CMS and CMMI to change models and waivers to foster greater alignment across markets and payers. For instance, the Advanced Payment Model in the MSSP offers a template and precedent for waivers to CMS and the creation of CMMI programs and initiatives when a need has been identified. Taken together, states have unprecedented opportunity to increase market competition and consumer choice—driving value in an aligned way across programs and populations.

Conclusion

State government is well positioned to drive improvement in the health status of communities. The three streams to this work – payment innovation, care delivery reform, and community health and wellness – should occur simultaneously and with coordination. When coupled with SIM resources, transformation should progress at an impressive rate. Governors should leverage the many important levers at their ready to impact health care delivery across Medicaid and the State Employee Health Benefit Program, and in coordination with providers and payers. They should also leverage their unique position to impact healthy living such as public health agencies, housing, environmental regulation, community development, taxation policies etc. All eyes should be on states as Governors leverage their many powers to redesign a well-financed health care delivery system with a new focus on dramatically improving the health of their state’s residents.

With a presence in nine SIM testing states, Trinity Health has convened a system-wide SIM Work Group to identify and share best practices, develop policy recommendations and position the organization as a trusted resource for state leaders. To learn more about SIM status, innovative approaches, early results and best practice sharing, visit Trinity Health’s State Resource Center for SIM leaders.

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