Medicaid Coverage and Innovation
Key Elements of People-Centered Health

November 2017
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• Promoting Coverage and Innovation Across Trinity Health’s Ministries and the Nation
Medicaid Policy Environment Fluid in Face of Coverage Expansion, Movement to Value and Budget Pressures

• **Coverage.** Since the Affordable Care Act (ACA) passed, 20 million individuals have gained coverage

• **Value.** Growing emphasis on value-based care has led to proliferation of P&D reforms in Medicaid, cross-payer initiatives

• **Budget Pressures.** As states continue to manage to their budgets, more are exploring Medicaid reforms

The Trump Administration’s focus on state-based reform - coupled with failed or stalled Congressional ACA reform and repair efforts - places Medicaid programs at the center of health system changes. While this creates opportunity to drive innovations and designing reforms that meet states’ unique political and population health needs, it also create the risk of eroding coverage expansions and value-based payment.
Medicaid Policy Development and Engagement Should Drive People-Centered Health

• The goals of this presentation are to:
  1. Identify key Medicaid policy trends and implications for Trinity Health’s People-Centered Health strategy
  2. Demonstrate the positive impacts of Medicaid coverage on the health of beneficiaries and communities
  3. Identify best practices and lessons learned across Trinity Health’s states to inform policy development and engagement
  4. Support Federal and State engagement with policy resources, such as the Medicaid Innovation Resource Center

Shifting economic and political priorities present challenges as Medicaid actors work to bolster access to coverage, advance value-based care initiatives and promote population health.

Policy responses and engagement opportunities differ across Trinity Health’s footprint but overall goal must be to promote a People-Centered Health System.
Section I
Strengthening Medicaid Coverage & Innovation to Build a People-Centered Health System
Trinity Health believes that People-Centered begins with people covered
- Medicaid reform and program changes should support better health, improved care and lower costs

- Drive Value-Based Care
  - Delivery System Reform Incentive Payment (DSRIP); Bundled Payments

- Promote Population Health
  - Reliance on Community-Health Workers, Efforts Targeting Behavioral Health

- Engage Beneficiaries
  - Health Risk Assessments; Preventative Care
States Will Continue to Use a Broad Range of Vehicles to Advance Reforms Across Payers

- **Section 1115 and 1332 Waivers**
  (e.g. MA’s 1115, AK’s 1332)

- **State Innovation Models**
  (OH’s Episodes of Care; NY’s PCMH model)

- **State-Based Initiatives**
  (OR’s ACOs)

- **Federally-Led Initiatives**
  (Financial Alignment Demonstration, PACE, CMMI demonstrations)

Trinity Health can leverage experience with advancing coverage and innovation through these vehicles (e.g. Indiana’s HIP 2.0, State Innovation Models, etc.) to share lessons learned with policymakers and stakeholders to advance next round of Medicaid changes.
1115 and 1332 Waivers Offer States Opportunity for Widespread Reform

• Section 1115 waivers are an important tool in new Administration
  - CMS Administrator Verma has experience working with state Medicaid programs to design and implement program changes, including using 1115 waivers
  - With political support, states are pursing waivers to pilot changes to their Medicaid program that have not been previously approved (e.g. work requirements)
  - May be used to implement structural and financing reforms in absence of federal reform

• Waivers are important vehicle for reform; allow broad-based changes
  - Section 1115 waivers give states significant flexibility to test reforms—they permit changes to state Medicaid programs not otherwise permitted under federal Medicaid law

• Growing focus on consumer responsibility reflected in new waivers
  - States are pursuing waivers that increase consumer responsibility; some policies are likely to have implications for coverage and access to needed services and drugs

States are also pursuing Section 1332 Waivers to implement Marketplace reforms. Stakeholders and policymakers exploring greater flexibility for 1332s – which may also move in tandem with Section 1115 waivers.
Most Trinity Health States Using 1115 Waivers to Implement P&D Reform, Use of 1332 Growing

<table>
<thead>
<tr>
<th>State</th>
<th>1115 Waiver</th>
<th>Status</th>
<th>1332 Waiver</th>
<th>Status</th>
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</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>X</td>
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<tr>
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<tr>
<td>Illinois</td>
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<td>Indiana</td>
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<tr>
<td>Iowa</td>
<td>X</td>
<td>Approved</td>
<td>X</td>
<td>Withdrew</td>
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</tbody>
</table>

*State has submitted new waiver or waiver renewal to CMS; approval pending as of 10/2017. Information current as of 10/26/2017
### Most Trinity Health States Using 1115 Waivers to Implement P&D Reform, Use of 1332 Growing

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<tr>
<th>State</th>
<th>1115 Waiver</th>
<th>Status</th>
<th>1332 Waiver</th>
<th>Status</th>
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</thead>
<tbody>
<tr>
<td>Maryland</td>
<td>X</td>
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<td></td>
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<tr>
<td>Massachusetts</td>
<td>X</td>
<td>Approved*</td>
<td>X</td>
<td>CMS: Preliminary Determination of Incomplete</td>
</tr>
<tr>
<td>Michigan</td>
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<tr>
<td>New Jersey</td>
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<tr>
<td>New York</td>
<td>X</td>
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<tr>
<td>North Carolina</td>
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<tr>
<td>Ohio</td>
<td></td>
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<td>X</td>
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<tr>
<td>Oregon</td>
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<td>Approved</td>
<td>X</td>
<td>Approved</td>
</tr>
</tbody>
</table>

*State has submitted new waiver or waiver renewal to CMS; approval pending as of 10/2017. Information current as of 10/26/2017
Trinity Health States Testing, Driving Innovation Through Medicaid Programs Across Country

| Statewide P&D | • Delivery System Reform Incentive Payment (DSRIP): CA, MA, NY, NJ  
| | • Accountable Care Organization: OR, MA  
| | • Episodes of Care: OH  
| | • Medicaid Health Homes: CT, IA, NY, MD, MI, NY, NC, OH  
| | • Patient-Centered Medical Homes: NY, OH, ID, CT  
| Population-Focused Initiatives | • Efforts to address the opioid epidemic (e.g. expensed access to SUD programs under MA’s 1115 waiver)  
| | • Integrated behavioral health services (e.g. integration of primary care and behavioral healthcare under ID’s SIM)  
| Healthcare Workforce | • Efforts to address workforce needs (e.g. ID’s use of Community Health Workers; MA’s proposal to increase employer responsibility for low-wage workers)  
| Quality and Accountability | • Cross-payer and Medicaid specific measure sets (e.g. NY’s cross-payer measure set)  
| | • Evaluating population outcomes (e.g. CT’s SIM dashboard)  
| Medicare & Medicaid Integration | • Program of All-Inclusive Care for the Elderly (PACE): AL, DE, IN, MA, MI, NJ, NY, NC, PA  
| | • Financial Alignment Demonstration: CA, IL, MA, MI, NY, OH
Assessing Trends and Leveraging Trinity Health’s Experience to Promote People-Centered Innovations

- Medicaid reform focused on strengthening coverage, promoting population health, implementing value-based payment reforms and engaging beneficiaries support a People-Centered Health System

- States continue to explore a range of approaches (e.g. Section 1115 waivers, SIM grants, Federal Initiatives) to implement innovations
  - Use of Section 1115 waivers has continued under current administration with focus now on increasing consumer responsibility
  - States with innovative payment and delivery reforms or population health efforts underway likely to continue, but may consider changes in new political environment
  - Increasing focus on Section 1332 Marketplace waivers and potential new flexibilities may create opportunities for intersection with Section 1115 Medicaid waivers
    - States may pursue 1332 and 1115s in tandem when scaling back Medicaid coverage (to 100% FPL) (e.g. MA)

As states—and Federal partners—continue to move forward with Medicaid reform and programmatic changes, Trinity Health can leverage lessons learned and best practices across its footprint – as well as evidence on the impact of coverage and access to promote better health, improved care and lower costs
Section II
Impacts of Medicaid Coverage and Innovation on Health Status and Costs
Medicaid Coverage and Access to Care Associated with Positive Benefits for Individuals, Communities

- Initial results from studies evaluating impact of Medicaid expansion and coverage have shown positive impacts on:
  - Health status and access to care
  - Enrollee and health systems’ costs
  - State economies and residents

The evidence of Medicaid’s impacts on beneficiaries and states should be part of communications and discussions with policymakers and stakeholders. Evidence-based policies and strategies could influence Medicaid reforms that aim to scale back coverage, benefits, enrollment or investments in value-based initiatives and population health.
Medicaid Coverage Increases Access to Care, Associated with Better Health Status

<table>
<thead>
<tr>
<th>Oregon</th>
<th>Ohio</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Study examining effects of Medicaid expansion on access and health outcomes for newly enrolled found:</td>
<td>• Study of OH’s 2014 Medicaid expansion’s impact on new enrollees found:</td>
</tr>
<tr>
<td>• Improved perceived access to care increased, specifically reporting having a usual place of care by 23.8%</td>
<td>• 64.3% of newly enrolled reported improved access to care (including those who previously had another form of insurance)</td>
</tr>
<tr>
<td>• An increase in utilization of preventive care and screening services</td>
<td>• 47.7% indicated an improvement in health and 27% had been newly diagnosed with a chronic condition</td>
</tr>
<tr>
<td>• A decrease in the rate of depression of 9.2%</td>
<td>• Roughly 33.9% of the expansion population reported fewer ED visits since enrolling in Medicaid</td>
</tr>
</tbody>
</table>

Highlighting the impacts of Medicaid coverage is critical to developing policies and advocating for protecting and expanding coverage and access to comprehensive benefits. Reform efforts should test and expand value-based care programs.
Medicaid Coverage Associated with Positive Financial Impacts on Enrollees, Health Systems

- **Medicaid expansion reduces financial strain on beneficiaries**
  - Analyses of the ACA Medicaid expansion have shown that insurance coverage reduces personal bankruptcies and improves credit scores
  - In expansion states, the percentage of low-income adults reporting unpaid Medicaid debt declined from 43% to 30% from 2012 to 2015
  - In Ohio, the percentage of expansion enrollees with medical debt decreased from 55.8% to 30.8% after enrolling in Medicaid coverage
  - Catastrophic expenditures decreased by almost 4.5% among those enrolled in Medicaid following Oregon’s Medicaid expansion

- **Medicaid expansion is associated with reduction in uncompensated care and per enrollee costs**
  - Nationally, per enrollee costs for newly eligible adults declined by 6.9% from 2015 to 2016
  - Hospitals in Medicaid expansion states saw an average annual decline of $2 million in uncompensated care costs between FY2013 and FY2014
    - Nationally, uncompensated care costs declined from $34.9 billion to $28.9 billion between 2013 and 2014, nearly all of which occurred in Medicaid expansion states

*Medicaid coverage reduces financial burden for low-income individuals, as well as uncompensated care costs. Reforms should avoid increasing financial burden on beneficiaries and providers, and focus on and focus on value-based programs to reduce costs.*
Medicaid Expansion Positively Impacts State Economies, Can Support Employment

- Expansion states realized budget savings, revenue gains and overall economic growth
  - **CO**: State created **31,074** additional jobs as a result of Medicaid expansion as of 2015-2016
  - **KY**: Report estimates that Medicaid expansion will create an estimated **40,000** jobs—with average salary of **$41,000**—and add **$30 billion** to the state’s economy through 2021
  - **OH**: More than **50%** of employed Medicaid expansion enrollees reported that Medicaid coverage made it easier to continue working

- In 2010, CMS projected that NHE would account for 19.8% of GDP in 2020. However, in 2016, CMS projected that NHE would account for 18.8% of GDP in 2020 – a full percentage point lower than pre-ACA projections

Medicaid plays an important role in state and local economies. There are measurable benefits to ensuring continuity of coverage and care for those states considering changes in coverage or imposing policies (e.g. work or related requirements) that place limits on beneficiaries.
Section III
Learning from Trinity Health States’ Experiences and Identifying Lessons Learned
Half of States in Trinity Health’s Footprint are Testing Cross-Payer Models

Washington is an example of a state with state-wide, advanced health care transformation. Examining states ahead of the curve can help inform and drive innovation in other states.
Trinity Health States Implementing Range of Cross-Payer Models With CMMI Demos & Federal Waivers

<table>
<thead>
<tr>
<th>State</th>
<th>Vehicle</th>
<th>Cross-Payer Models</th>
<th>Payers Involved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connecticut</td>
<td>State Innovation Model</td>
<td>Medical Homes</td>
<td>Medicaid/ CHIP, Medicare. Commercial (including ESI), Marketplace</td>
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<tr>
<td>Delaware</td>
<td>State Innovation Model</td>
<td>ACO</td>
<td>Medicaid/ CHIP, Medicare, potentially State Employees (aligns w/ Comm.)</td>
</tr>
<tr>
<td>Idaho</td>
<td>State innovation Model</td>
<td>PCMH</td>
<td>Medicaid/ CHIP, Commercial, State Employees, potentially Medicare</td>
</tr>
<tr>
<td>Iowa</td>
<td>State innovation Model</td>
<td>ACO</td>
<td>Medicaid, (alignment with Medicare, Wellmark’s ACO/VBP arrangements)</td>
</tr>
<tr>
<td>Nebraska</td>
<td>CPC+</td>
<td>PCMH</td>
<td>Medicare, Commercial</td>
</tr>
<tr>
<td>Maryland</td>
<td>Federal/State Waiver:</td>
<td>All-Payer Hospital Rate System</td>
<td>All Payers (Medicare, Medicaid, Commercial)</td>
</tr>
<tr>
<td>Michigan</td>
<td>State Innovation Model</td>
<td>PCMH, ACO</td>
<td>Medicaid/CHIP, Commercial, Medicare</td>
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<tr>
<td></td>
<td>CPC+</td>
<td>PCMH</td>
<td>Medicare, Commercial</td>
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</table>

Source: Trinity Health SIM Workgroup, CPC+ Round 1 Participating Regions & Payer Partners, CPC+ Round 2 Participating Regions & Provisional Payer Partners
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<tr>
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<td></td>
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<tr>
<td>Ohio</td>
<td>State Innovation Model</td>
<td>PCMH</td>
<td>Medicaid, State Employee, Commercial (including ESI), potentially Medicare</td>
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<tr>
<td></td>
<td>State Innovation Model</td>
<td>Episode of Care</td>
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<tr>
<td></td>
<td>CPC+</td>
<td>PCMH</td>
<td>Medicare, Medicaid, Commercial</td>
</tr>
<tr>
<td>Oregon</td>
<td>State Initiative/State Innovation Model</td>
<td>CCOs (PCMH, Team-Based Care, ACO)</td>
<td>Medicaid/CHIP, Medicare, Public Employees, Comm.</td>
</tr>
<tr>
<td></td>
<td>CPC+</td>
<td>PCMH</td>
<td>Medicare, Medicaid, Commercial</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>Federal/State Waiver</td>
<td>Pennsylvania Rural Health Model</td>
<td>All Payers (Medicare, Medicaid, Commercial)</td>
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<tr>
<td></td>
<td>CPC+</td>
<td>PCMH</td>
<td>Medicare, Commercial</td>
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Some states (NY and OH) are exploring alignment of Medicaid and cross-payer initiatives with Advanced APMs under MACRA.

Source: Trinity Health SIM Workgroup, CPC+ Round 1 Participating Regions & Payer Partners, CPC+ Round 2 Participating Regions & Provisional Payer Partners
Oregon’s Medicaid Reforms Driving Statewide Changes

Oregon - Coordinated Care Organizations

- OR is using a combination of a state-based initiatives and a Section 1115 waiver to implement statewide access to CCOs—ACO-like models that provide integrated physical, behavioral and oral health services.

Movement to Value

In 2013, 90% of Medicaid enrollees were in CCOs. State aims to have all Oregon Health Authority covered lives and 75% of all residents receiving care through a PCMH.

Payment Reform

CCO’s are required to implement at least one alternative payment model (i.e. pay-for-performance, shared savings/risk, or EOC based payments).

Results

The state’s CCO model has resulted in almost half of Oregonians benefitting from PCMHs, fewer ER visits and fewer hospitalizations.

Initial findings from Oregon’s initiative show model is improving care and reducing use of some high-cost services, underscoring potential for Medicaid-driven reforms to have statewide impacts.
New York DSRIP on Track to Meet Utilization Goals

New York: DSRIP

- NY is using a section 1115 waiver to implement a DSRIP Program. State is using Performing Provider Systems (PPSs) staffed by regional entities, which include hospitals, behavioral health, primary care, health home, and community based service providers to implement projects targeted at establishing and improving a regional and statewide population health infrastructure designed to improve care and reduce avoidable inpatient and emergency care utilization.

- **Managing Care**
  NY is on track to meet goal to reduce avoidable hospital use by 25% by year 5 (2021)

- **Controlling Costs**
  NY saw a 14.9% reduction in potentially preventable readmissions, and an 11% reduction in potentially preventable ER visits

- **Value-Based Payments**
  DSRIP assessment found that through Y2 (2016), PPS' earned 95% of available funds ($2.4B) for achieving process measures

- **Other Reforms**: NY is also implementing other Medicaid and multi-payer reforms including a State Innovation model, Medicaid Health Homes, value-based purchasing pilots and programs with MCO’s, providers, and health systems, and a Financial Alignment Demonstration for dual eligibles.

NY set ambitious goals to establish PPS’s and reduce inpatient utilization. Early results indicate that DSRIP initiatives can catalyze utilization changes and provider performance and accountability.
Ohio Initiatives Are Expansive, Aligning with Federal Payment Reform

**Ohio: Episodes of Care**

- Under its SIM, Ohio is implementing 50 bundled payments or EOCs—and PCMHs—state-wide as part of its State Innovation Model (SIM) grant

<table>
<thead>
<tr>
<th>Model Scope</th>
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<tbody>
<tr>
<td><strong>Cross-payer:</strong> Includes Medicaid, commercial, state employees and potentially Medicare</td>
</tr>
<tr>
<td><strong>EOC Design:</strong> EOCs target high-cost conditions or diagnoses; aim to incentivize provider accountability for high-quality care through shared savings with risk</td>
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<thead>
<tr>
<th>Movement to Value</th>
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<tbody>
<tr>
<td>To date, Ohio has launched 32 EOCs</td>
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<tr>
<td>State plans to launch 30 additional EOCs in 2017</td>
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<thead>
<tr>
<th>Alignment with Federal Reform</th>
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<tbody>
<tr>
<td>OH aims to align PCMH program with the federal Comprehensive Primary Care Plus initiative; will help providers qualify for increased bonus payments under the Medicare Access and CHIP Reauthorization Act (MACRA)</td>
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</table>

- **Other Reforms:** Ohio has also implemented Medicaid Health Homes for select beneficiaries and a capitated Financial Alignment Demonstration for dual eligibles.

Ohio’s model is one of the largest bundled payment initiatives in the country, and the state is trying to align with major Medicare payment reforms – underscoring potential for cross-payer models.
Massachusetts: Accountable Care Organizations

- Massachusetts is using its waiver to implement a statewide Medicaid ACO delivery system to:
  - Improve care integration (including behavioral health and long-term services and supports),
  - Support safety net care redesign, and
  - Expand substance use disorders (SUD) programs to combat the opioid crisis

- State proposed three payment and care models for ACO-allowing for flexibility:
  - Accountable Care Partnership (ACO/MCO) - prospective capitated rate (includes BH; LTSS phased- in years 3/4)
  - Primary Care ACOs (ACO contracts w/ state) - shared savings/losses based on TCOC, quality perf. (Behavioral Health carved out)
  - Primary Care ACOs (ACO contracts w/ state) - shared savings/losses based on TCOC, quality performance (Behavioral Health carved out)

Waivers can test and implement statewide accountable care approaches that aim to drive savings and improve care by integrating care across settings and targeting high-cost and high-need conditions.
Medicaid Programs Are Leading Advances in Population Health

Iowa

- IA is using six Community Care Coalition Communities to drive health care transformation
- Model includes focus on population health initiatives - tobacco, obesity, and diabetes interventions

Michigan

- MI is creating Community Health Innovation Regions (CHIRs) to connect patients with local community services and leverage public health efforts to address determinants of health

Idaho

- ID’s seven public health districts are serving as Regional Collaboratives (RCs) supporting local practices as they transform to PCMHs
- RCs also serve as public health/physical health integrators, linking practices to broader medical neighborhood (e.g. community services)

Medicaid reforms should maintain or expand population health initiatives that are critical for improving health outcomes and reducing costs among Medicaid beneficiaries. Communicating their value to states and communities is critical.
Medicaid Program Can Encourage Beneficiary Engagement Without Impeding Access to Care

**Healthy Indiana Plan (HIP) 2.0**

- HIP 2.0 waiver allows enrollees, who contribute to a health savings account (HSA), to access benefits not otherwise available, including dental and vision.
- Enrollees that do not make payments to an HSA are enrolled in a basic coverage plan and required to pay cost sharing.
- Under the waiver, 390,000 individuals gained Medicaid coverage as of December 2016.

**Michigan Health Risk Assessment**

- During enrollment, Medicaid beneficiaries can fill out a voluntary health risk assessment (HRA) and complete form with their primary care provider.
- Between January 2014 and March 2017, 83% of beneficiaries with income up to 100% FPL completed the HRAs, with 60% of respondents identifying more than one health risk (e.g. weight, tobacco cessation) to address.

**Beneficiary engagement policies must be implemented in a way that ensure they do not lead to reduced enrollment, barriers to accessing necessary care, and worse health outcomes.**
CMS & MD Testing All-Payer Hospital Global Payment Model; Phase II Will Expand Beyond Hospital Setting

- Maryland’s current All-Payer Model builds on an original all-payer rate-setting Medicare Waiver (1977) (only covered inpatient services) to test if a total-cost-of-care model could improve health and quality of care while reducing costs.

- Phase II of the All-Payer Model will build on Phase I’s progress to further limit TCOC growth, and will likely align with the MACRA (state is seeking Advanced Alternative Payment Model designation for hospitals).

**All-Payer Model (2014 – 2018)**

- Recognizes outpatient services under payment; shifts some care from inpatient setting.
- Includes fixed base hospital revenue at the beginning of the year – not based on units (adjusted, as needed, for trends/value) giving hospitals predictable revenue.
- Over 5 years, shifts virtually all hospital revenue into global payment model.
- Requires state to meet financial, quality (readmissions and hospital acquired conditions), and population health goals.

**All-Payer Model – Phase II (2019)**

- Builds on all-payer hospital model to promote transformation beyond the hospital setting and drive quality improvements - elements will likely include:
  - **Hospital.** Changes to TCOC will include limit to TCOC growth rate; likely to include non-hospital, Part B costs.
    - In 2016, state developed Care Redesign Amendment programs for hospital participation to ease transition to Phase II TCOC requirements.
  - **Primary Care.** Comprehensive Primary Care Model (CPC+ like) “Person-Centered Homes (PCH)” will incorporate utilization, quality measures, care management.
  - **Dual-Eligibles.** Duals model will include ACOs and PCMHs depending on duals population.

Preliminary Year 2 (2016) results found: minimal per capita growth in all-payer revenue; 100% of hospital payments were made through global budgets/population-based payments; $287M in overall Medicare savings for hospital expenditures; and, a reduction in composite QM of preventable conditions of 43% since 2013.

**Sources:**
- Phase II Updated Progression Plan (submitted to CMS 12/2016); A brief background and summary of the Total Cost of Care Model with key requirements; All-Payer Model Performance, through 2016 Year-to-Date Results; Maryland Comprehensive Primary Care Model Concept Paper (submitted to CMS 12/2017).
What Key Factors Help Drive State Innovation?

- **Infrastructure** (Health IT, Governance Structure)
- **Multi-Stakeholder Engagement** (Consumers, Issuers, Providers, Community)
- **Strong Leadership** (Gubernatorial, Administration’s Support)
- **Evaluation and Measurement** (Consistent Metrics & Data Infrastructure)
- **Payment & Delivery Reform** (Includes Risk, Cross-payer alignment)
- **Population Health Components** (e.g. behavioral health integration)
- **Integrated Care Across Continuum of Services /Providers**
Section IV
Promoting Coverage and Innovation Across Trinity Health’s Ministries and the Nation
Trinity Health’s Commitment to a People-Centered Health System Guides Advocacy

- Trinity Health has developed a set of safeguards to promote dialogue around how to strengthen and innovate within the Medicaid program.

- Key Principles include:
  1. Support comprehensive and affordable coverage and care
  2. Ensure sustainable and shared federal and state funding
  3. Drive value-based care
Trinity Health’s Commitment to a People-Centered Health System Guides Advocacy

Comprehensive, Affordable Coverage
- Provide comprehensive benefits w/access to necessary services
- Ensure cost sharing increases engagement without limiting access
- Promote continuity of and access to coverage across life changes and health care needs

Sustainable, Shared Federal and State Financing
- Support Medicaid expansion in all states
- Strengthen safety net programs and uncompensated care pools
- Ensure any financial reform incl. appropriate inflationary updates, triggers

Value-Based Care
- Continue investments in APMs that drive accountability, reduce costs
- Implement delivery system models that promote care coordination across settings
- Drive cross-payer initiatives to impact population health
Medicaid Innovation Resource Center

• Trinity Health’s Medicaid Innovation Resource Center includes tools and resources to help policymakers and stakeholders ensure that programs maintain access to coverage and care—especially for the most vulnerable—and incentivize accountability.

• The Resource Center supports assessing the potential impacts of Medicaid trends and innovations on states and beneficiaries, and identifies policies that support a people-centered system of care.

Medicaid Innovation Resource Center

Trinity Health is building a People-Centered Health System to put the people we serve at the center of every behavior, action and decision. This brings to life our commitment to be a compassionate, transforming and healing presence in our communities. We believe that innovation within the Medicaid program creates the opportunity for states to implement public policies that support better health, better care and lower costs to ensure affordable, high-quality, people-centered care for all. Trinity Health believes that states are uniquely positioned to drive health system transformation as well as the health and well-being of our communities. Through engagement with states and at the federal level, we have worked to promote policies that support these goals.

This Medicaid Innovation Resource Center includes public policy tools and resources to help state and federal policymakers and other stakeholders ensure that innovations within the Medicaid program maintain access to coverage and needed care—especially for the most vulnerable—and incentivize accountability for outcomes and costs while ensuring stable funding for years to come.

The tools included aim to help stakeholders assess the impact of emerging policy trends and innovations within the Medicaid program on states, beneficiaries and care; and to help identify and promote policies that best support a people-centered system of care.
Education is Empowering
Learn more at: http://advocacy.trinity-health.org/home
Sources


- Centers for Medicare and Medicaid Services, NHE Projections: 2016-2015, Table 1 “National Health Expenditures and Selected Economic Indicators, Levels and National Health Expenditure Projections 2010-2020

- Centers for Medicare and Medicaid Services, “Annual Percent Change: Calendar Years 2009-2025”


