



Transforming Payment for a Healthier Ohio

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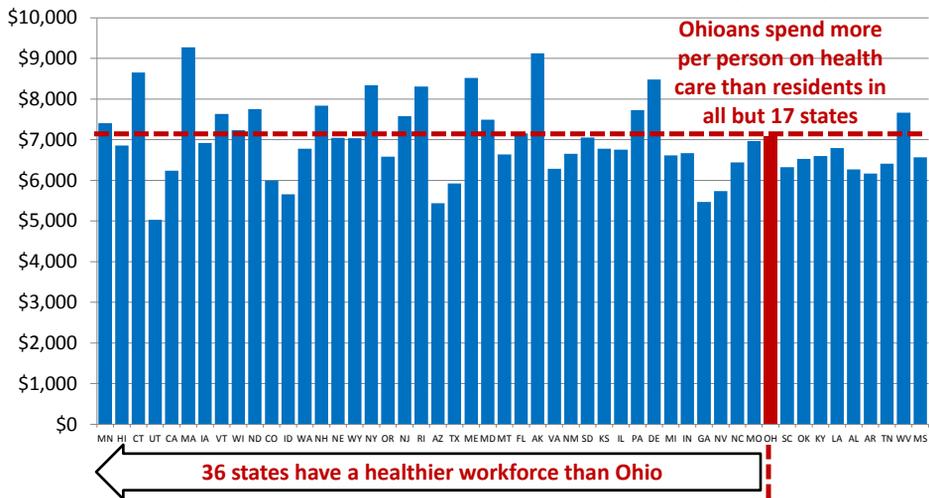
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| 2011 Ohio Crisis | vs. | Results Today |
|--|-----|---|
| <ul style="list-style-type: none"> • \$8 billion state budget shortfall • 89-cents in the rainy day fund • Nearly dead last (48th) in job creation (2007-2009) • Medicaid spending increased 9% annually (2009-2011) • Medicaid over-spending required multiple budget corrections • Ohio Medicaid stuck in the past and in need of reform • More than 1.5 million uninsured Ohioans (75% of them working) | | <ul style="list-style-type: none"> • Balanced budget • \$1.5 billion in the rainy day fund • Ranked 5th in the nation in job creation (2011-2013) • Medicaid spending increased 3% annually (2012-2013) • Medicaid under-spending topped \$950 million (2012-2013) • Ohio Medicaid looks to the future and embraces transformation • Extended Medicaid coverage |

|  Governor's Office of Health Transformation | | | Innovation Framework |
|---|--|--|----------------------|
| Modernize Medicaid | Streamline Health and Human Services | Pay for Value | |
| <i>Initiate in 2011</i> | <i>Initiate in 2012</i> | <i>Initiate in 2013</i> | |
| <i>Advance the Governor Kasich's Medicaid modernization and cost containment priorities</i> | <i>Share services to increase efficiency, right-size state and local service capacity, and streamline governance</i> | <i>Engage private sector partners to set clear expectations for better health, better care and cost savings through improvement</i> | |
| <ul style="list-style-type: none"> • Extend Medicaid coverage to more low-income Ohioans • Eliminate fraud and abuse • Prioritize home and community services • Reform nursing facility payment • Enhance community DD services • Integrate Medicare and Medicaid benefits • Rebuild community behavioral health system capacity • Create health homes for people with mental illness • Restructure behavioral health system financing • Improve Medicaid managed care plan performance | <ul style="list-style-type: none"> • Create the Office of Health Transformation (2011) • Implement a new Medicaid claims payment system (2011) • Create a unified Medicaid budget and accounting system (2013) • Create a cabinet-level Medicaid Department (July 2013) • Consolidate mental health and addiction services (July 2013) • Simplify and replace Ohio's 34-year-old eligibility system • Coordinate programs for children • Share services across local jurisdictions • Recommend a permanent HHS governance structure | <ul style="list-style-type: none"> • Participate in Catalyst for Payment Reform • Support regional payment reform initiatives • Pay for value instead of volume (State Innovation Model Grant) <ul style="list-style-type: none"> – Provide access to medical homes for most Ohioans – Use episode-based payments for acute events – Coordinate health information infrastructure – Coordinate health sector workforce programs – Report and measure system performance | |

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1. Ohio Approach to Paying for Value Instead of Volume
 2. Patient-Centered Medical Home Model
 3. Episode-Based Payment Model

Health Care Spending per Capita by State (2011) in order of resident health outcomes (2009)



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Sources: CMS Health Expenditures by State of Residence (2011); The Commonwealth Fund, *Aiming Higher: Results from a State Scorecard on Health System Performance* (October 2009).

In fee-for-service, we get what we pay for

- **More volume** – to the extent fee-for-service payments exceed costs of additional services, they encourage providers to deliver more services and more expensive services
- **More fragmentation** – paying separate fees for each individual service to different providers perpetuates uncoordinated care
- **More variation** – separate fees also accommodate wide variation in treatment patterns for patients with the same condition – variations that are not evidence-based
- **No assurance of quality** – fees are typically the same regardless of the quality of care, and in some cases (e.g., avoidable hospital readmissions) total payments are greater for lower-quality care



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Source: UnitedHealth, *Farewell to Fee-for-Service: a real world strategy for health care payment reform* (December 2012)

Center for Medicare & Medicaid INNOVATION

27 states are designing and testing payment innovation programs

■ SIM Design
■ SIM Testing
★ CPCi Testing

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SIM: State Innovation Model; CPCi: Comprehensive Primary Care Initiative
SOURCE: U.S. Centers for Medicare and Medicaid Services (CMS).

Shift to population-based and episode-based payment

| Payment approach | Most applicable |
|---|---|
| <div style="background-color: #003366; color: white; padding: 10px; text-align: center;"> Population-based (PCMH, ACOs, capitation) </div> <div style="background-color: #0070C0; color: white; padding: 10px; text-align: center; margin: 5px 0;"> Episode-based </div> <div style="background-color: #0070C0; color: white; padding: 10px; text-align: center; margin: 5px 0;"> Fee-for-service (including pay for performance) </div> | <ul style="list-style-type: none"> ▪ Primary prevention for healthy population ▪ Care for chronically ill (e.g., managing obesity, CHF) <hr style="border-top: 1px dotted #000;"/> <ul style="list-style-type: none"> ▪ Acute procedures (e.g., CABG, hips, stent) ▪ Most inpatient stays including post-acute care, readmissions ▪ Acute outpatient care (e.g., broken arm) <hr style="border-top: 1px dotted #000;"/> <ul style="list-style-type: none"> ▪ Discrete services correlated with favorable outcomes or lower cost |

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- Goal** 80-90 percent of Ohio's population in some value-based payment model (combination of episodes- and population-based payment) within five years
- State's Role**
- Shift rapidly to PCMH and episode model in Medicaid fee-for-service
 - Require Medicaid MCO partners to participate and implement
 - Incorporate into contracts of MCOs for state employee benefit program

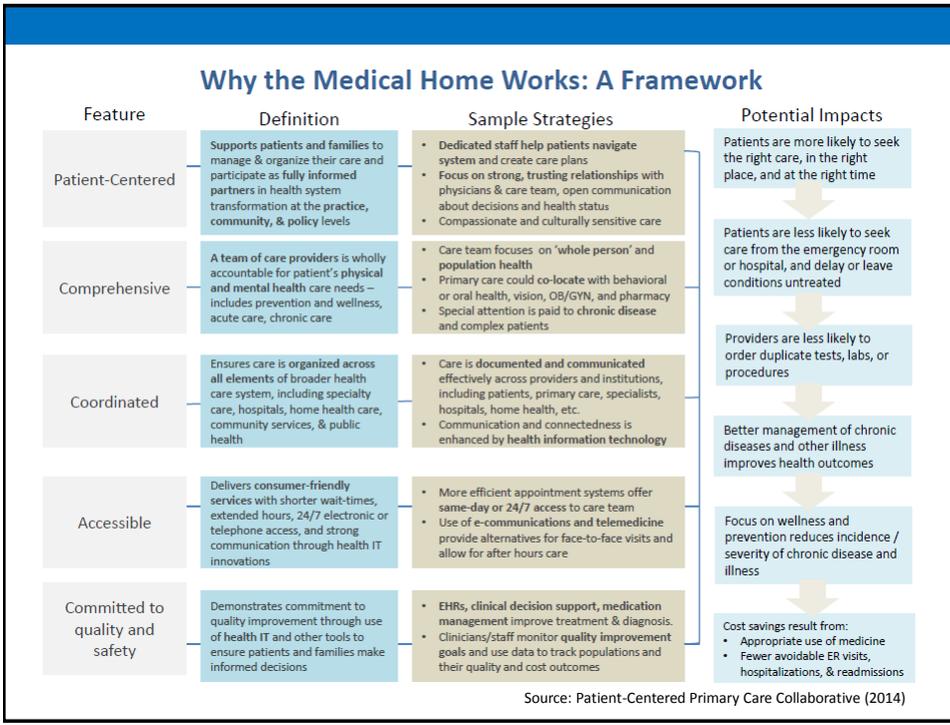
| | Patient-centered medical homes | Episode-based payments |
|---------------|--|--|
| Year 1 | <ul style="list-style-type: none"> ▪ In 2014 focus on Comprehensive Primary Care Initiative (CPCI) ▪ Payers agree to participate in design for elements where standardization and/or alignment is critical ▪ Multi-payer group begins enrollment strategy for one additional market | <ul style="list-style-type: none"> ▪ State leads design of five episodes: asthma acute exacerbation, perinatal, COPD exacerbation, PCI, and joint replacement ▪ Payers agree to participate in design process, launch reporting on at least 3 of 5 episodes in 2014 and tie to payment within year |
| Year 3 | <ul style="list-style-type: none"> ▪ Model rolled out to all major markets ▪ 50% of patients are enrolled | <ul style="list-style-type: none"> ▪ 20 episodes defined and launched across payers |
| Year 5 | <ul style="list-style-type: none"> ▪ Scale achieved state-wide ▪ 80% of patients are enrolled | <ul style="list-style-type: none"> ▪ 50+ episodes defined and launched across payers |

Ohio's Health Care Payment Innovation Partners:





1. Ohio Approach to Paying for Value Instead of Volume
2. Patient-Centered Medical Home Model
3. Episode-Based Payment Model



Benefits of Implementing a PCMH

| PCMH | Fewer ED visits | Fewer Hospital Admissions | Cost savings |
|-----------------------------|-----------------|---------------------------|----------------------------|
| Alaska Medical Center | 50% | 53% | |
| Capital Health Plan, FL | 37% | | 18% lower claims costs |
| Geisinger Health System, PA | | 25% | 7% lower total spending |
| Group Health of Washington | | 15% | \$15 million (2009-2010) |
| HealthPartners, MI | 39% | 40% | |
| Horizon BCBS, NJ | | 21% | |
| Maryland CareFirst BCBS | | | \$40 million (2011) |
| Vermont Medicaid | 31% | | 22% lower PMPM (2008-2010) |



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Source: Patient-Centered Primary Care Collaborative, "Benefits of Implementing the PCMH: A Review of Cost and Quality Results (2012)"



Comprehensive Primary Care Initiative

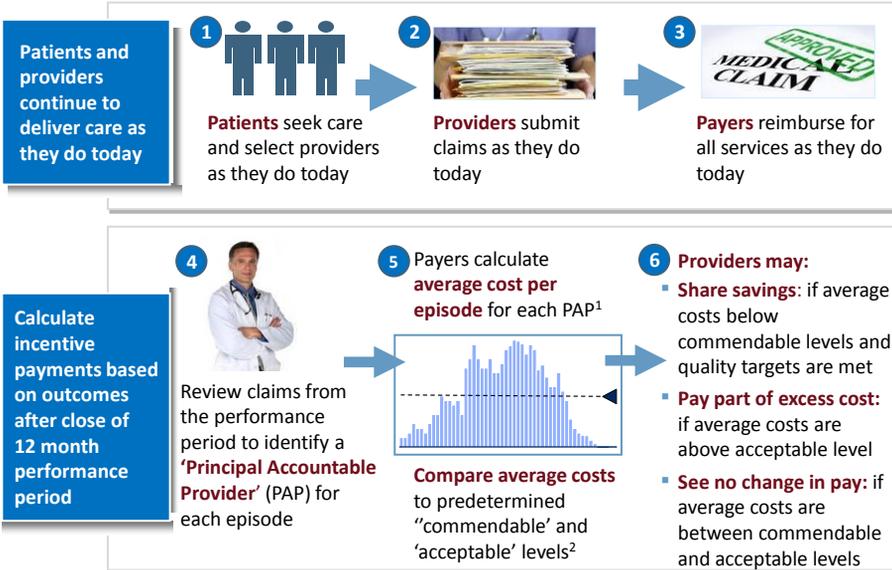
- Dayton/Cincinnati is one of only seven CPCI sites nationally
- Bonus payments to primary care doctors who better coordinate care
- Multi-payer: Medicare, Medicaid, nine commercial insurance plans
- 75 primary care practices (261 providers) serving 44,500 Medicare enrollees in 14 Ohio and 4 Kentucky counties
- Practices were selected based on their use of HIT, advanced primary care recognition, and participation in practice improvement activities
- Supported by a unique regional collaborative: The Greater Cincinnati Health Council, the Health Collaborative, and HealthBridge



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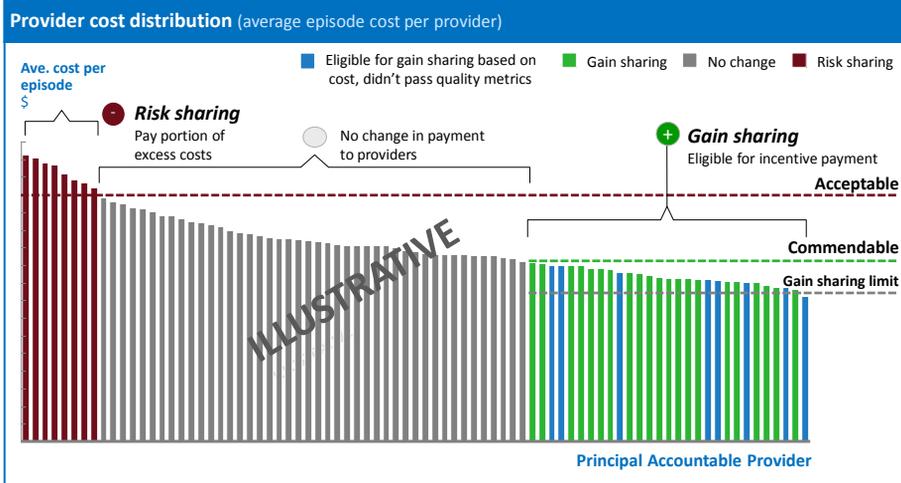
Source: www.innovations.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/Ohio-Kentucky

Retrospective episode model mechanics



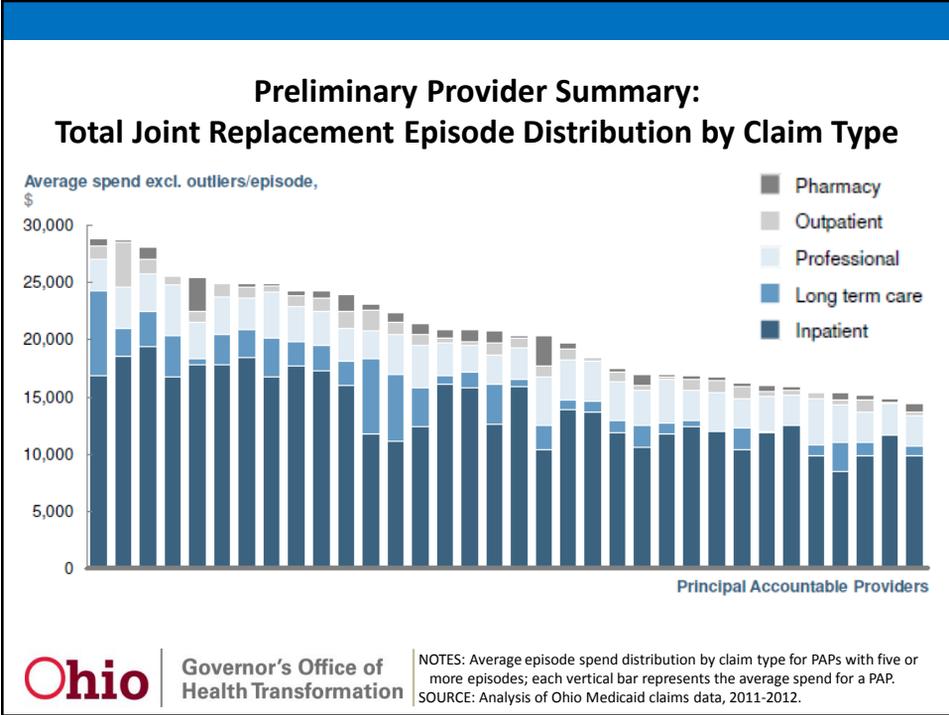
SOURCE: Arkansas Payment Improvement Initiative

Retrospective thresholds reward cost-efficient, high-quality care



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SOURCE: Arkansas Payment Improvement Initiative; each vertical bar represents the average cost for a provider, sorted from highest to lowest average cost



Selection of episodes in the first year

Guiding principles for selection:

- Leverage episodes in use elsewhere to **reduce time to launch**
- Prioritize meaningful **spend across payer populations**
- Look for opportunities with **clear sources of value** (e.g., high variance in care)
- Select episodes that incorporate a **diverse mix** of accountable **providers** (e.g., facility, specialists)
- Cover a **diverse set of "patient journeys"** (e.g., acute inpatient, acute procedural)
- Consider **alignment with current priorities** (e.g., perinatal for Medicaid, asthma acute exacerbation for youth)

Working hypothesis for episodes in the first year:

- Perinatal
- Asthma acute exacerbation
- Chronic obstructive pulmonary disease (COPD) exacerbation
- Joint replacement
- Acute and non-acute percutaneous coronary intervention (PCI)

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CURRENT INITIATIVES | BUDGETS | NEWSROOM | CONTACT | VIDEO

Current Initiatives

Ohio's Innovation Model Test Grant Application

- Population Health Plan
- Delivery System Plan
- Payment Models
- Regulatory Plan
- HIT Plan
- Stakeholder Engagement
- Quality Measurement

Multi-Payer PCMH Charter

- Multi-Payer Episode Charter
- Detailed Episode Definitions

Modernize Medicaid
 Extend Medicaid coverage to more low-income Ohioans
 Reform nursing facility reimbursement
 Integrate Medicare and Medicaid benefits
 Prioritize home and community based services
 Create health homes for people with mental illness
 Rebuild community behavioral health system capacity
 Enhance community developmental disabilities services
 Improve Medicaid managed care plan performance

Streamline Health and Human Services
 Implement a new Medicaid claims payment system
 Create a cabinet-level Medicaid department
 Consolidate mental health and addiction services
 Simplify and integrate eligibility determination
 Coordinate programs for children
 Share services across local jurisdictions

Pay for Value
 Engage partners to align payment innovation
 Provide access to patient-centered medical homes
 Implement episode-based payments
 Coordinate health information technology infrastructure
 Coordinate health sector workforce programs
 Support regional payment reform initiatives
 Federal Health Insurance Exchange

Ohio's Innovation Model

- Governor Kasich created the Office of Health Transformation to improve overall health system performance
- Pay for health care value instead of volume across Medicaid, state employee, and commercial populations
 - Launch episode based payments in November 2014
 - Take Comprehensive Primary Care to scale in 2015
- Partners include Anthem, Aetna, CareSource, Medical Mutual, and UnitedHealthcare, covering ten million Ohioans
- Build on momentum from extending Medicaid coverage, Medicare-Medicaid Enrollee project, Medicaid health home
- Comprehensive, complementary strategies for health sector workforce development and health information technology
- Active stakeholder participation – 150+ stakeholder experts, 50+ organizations, 60+ workshops, 15 months and counting ...

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