Ohio | Governor's Office of Health Transformation

Transforming Payment for a Healthier Ohio

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Akron General Health System
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www.HealthTransformation.Ohio.gov

2011 Ohio Crisis

- $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)

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Innovation Framework

Modernize Medicaid	Streamline Health and Human Services	Pay for Value
Initiate in 2011	***Initiate in 2012***	***Initiate in 2013***
Advance the Governor Kasich's Medicaid modernization and cost containment priorities	*Share services to increase efficiency, right-size state and local service capacity, and streamline governance*	*Engage private sector partners to set clear expectations for better health, better care and cost savings through improvement*
• 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	• 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	• Participate in Catalyst for Payment Reform • Support regional payment reform initiatives • Pay for value instead of volume (State Innovation Model Grant) - 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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2011 Ohio Crisis	vs. Results Today
• $8 billion state budget shortfall	• Balanced budget
• 89-cents in the rainy day fund	• $1.5 billion in the rainy day fund
• Nearly dead last (48th) in job creation (2007-2009)	• Ranked 5th in the nation in job creation (2011-2013)
• Medicaid spending increased 9% annually (2009-2011)	• Medicaid spending increased 3% annually (2012-2013)
• Medicaid over-spending required multiple budget corrections	• Medicaid under-spending topped $950 million (2012-2013)
• Ohio Medicaid stuck in the past and in need of reform	• Ohio Medicaid looks to the future and embraces transformation
• More than 1.5 million uninsured Ohioans (75% of them working)	• Extended Medicaid coverage

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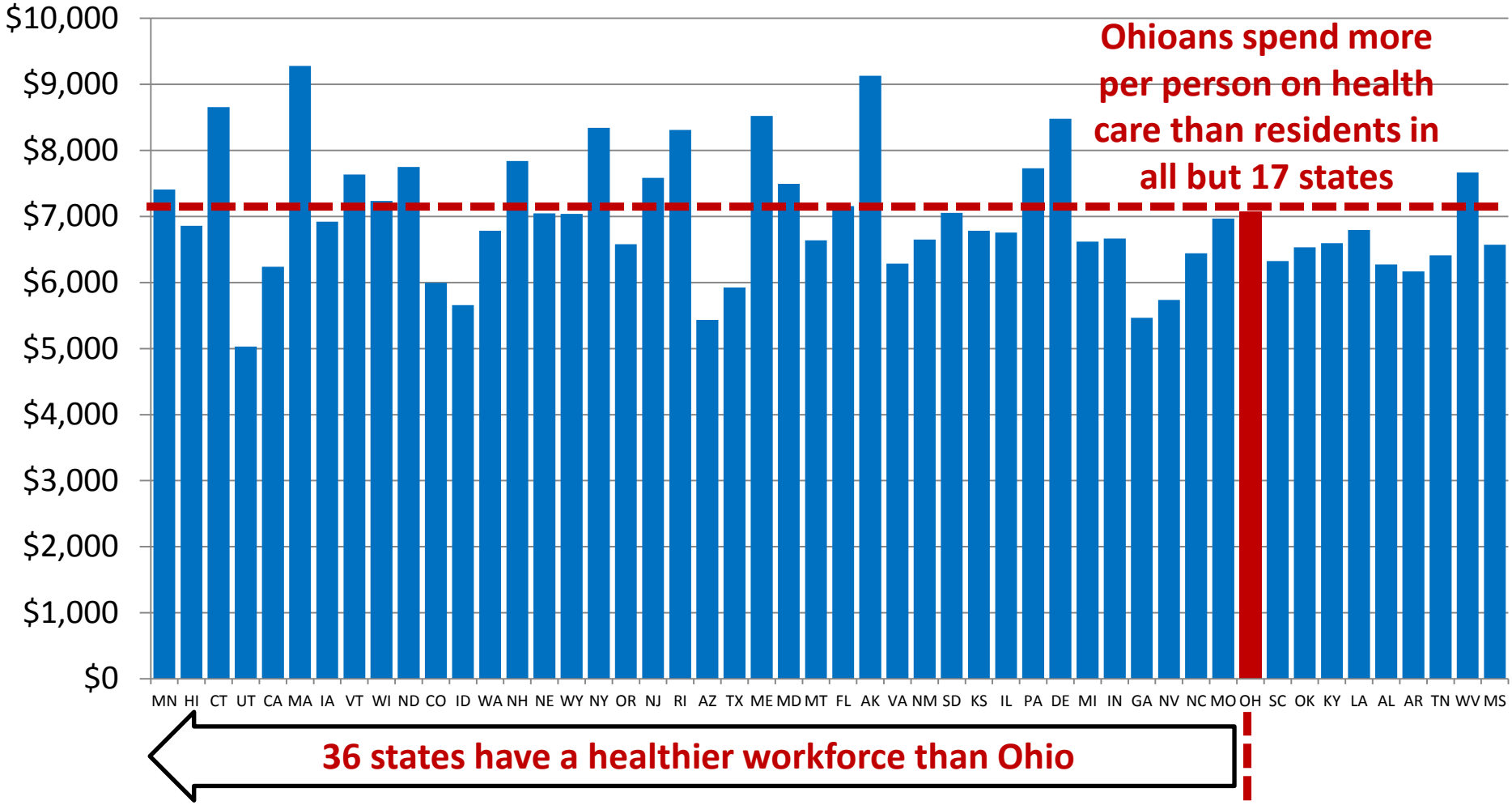
1. Ohio Approach to Paying for Value Instead of Volume
2. Patient-Centered Medical Home Model
3. Episode-Based Payment Model

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).

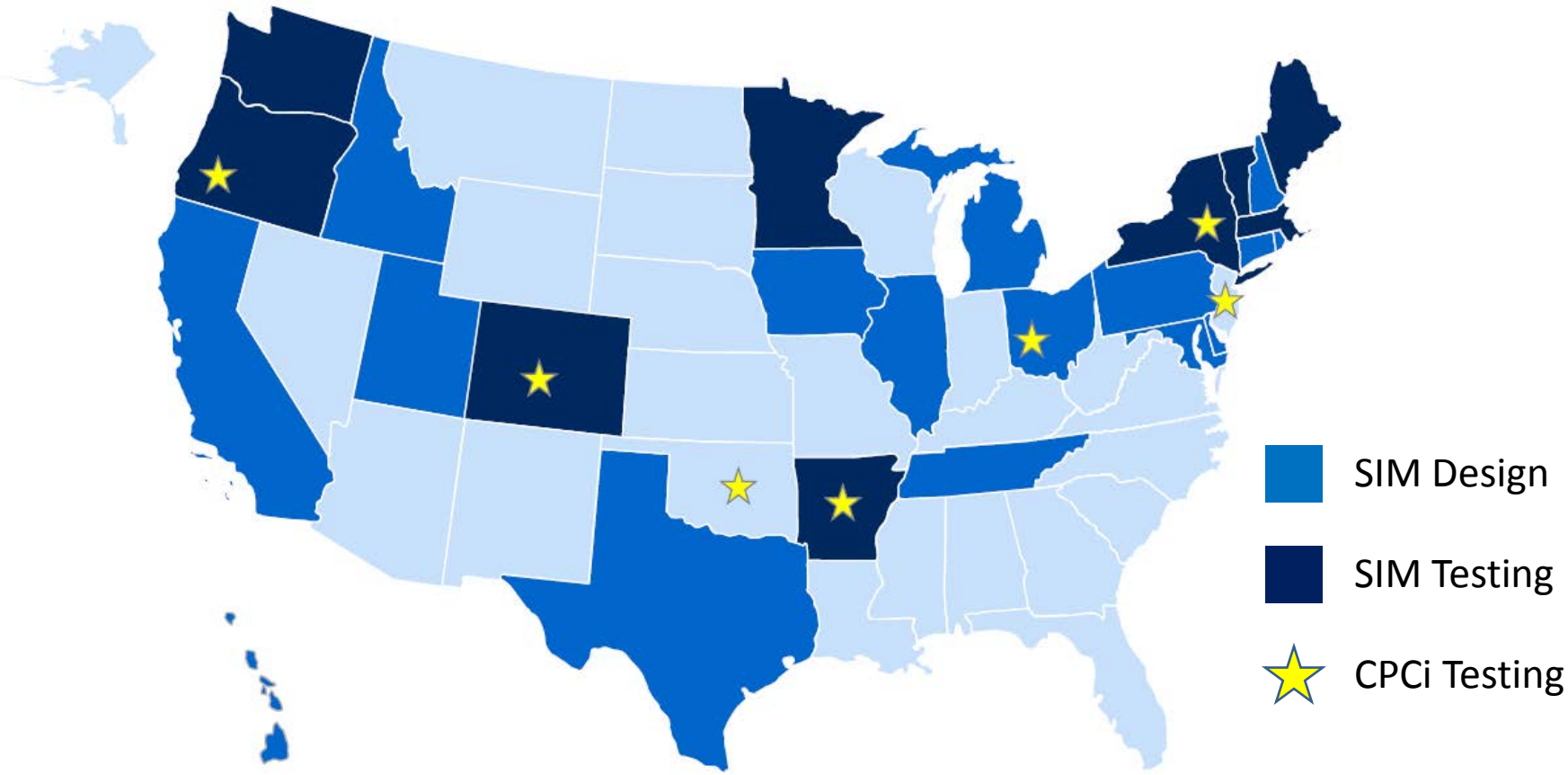
In fee-for-service, we get what we pay for

- **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

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



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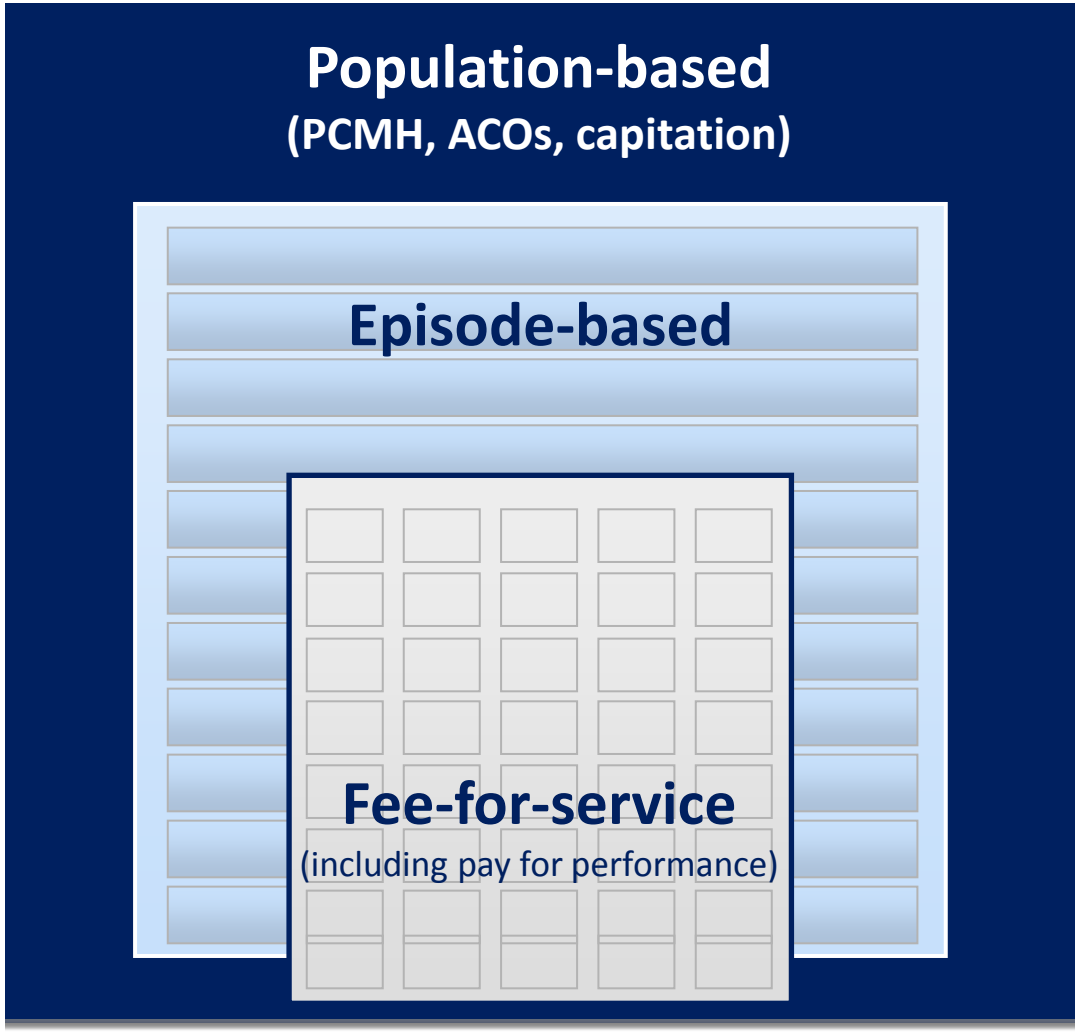
SIM: State Innovation Model; CPCI: Comprehensive Primary Care Initiative
SOURCE: U.S. Centers for Medicare and Medicaid Services (CMS).

Shift to population-based and episode-based payment

Payment approach



Most applicable

- Primary prevention for healthy population
- Care for chronically ill (e.g., managing obesity, CHF)

- Acute procedures (e.g., CABG, hips, stent)
- Most inpatient stays including post-acute care, readmissions
- Acute outpatient care (e.g., broken arm)

- Discrete services correlated with favorable outcomes or lower cost

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5-Year Goal for Payment Innovation

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	▪ 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	▪ 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	▪ Model rolled out to all major markets ▪ 50% of patients are enrolled	▪ 20 episodes defined and launched across payers
Year 5	▪ Scale achieved state-wide ▪ 80% of patients are enrolled	▪ 50+ episodes defined and launched across payers

Ohio's Health Care Payment Innovation Partners:

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1. Ohio Approach to Paying for Value Instead of Volume
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Why the Medical Home Works: A Framework

Feature	Definition	Sample Strategies
Patient-Centered	Supports patients and families to manage & organize their care and participate as fully informed partners in health system transformation at the practice, community, & policy levels	• Dedicated staff help patients navigate system and create care plans • Focus on strong, trusting relationships with physicians & care team, open communication about decisions and health status • Compassionate and culturally sensitive care
Comprehensive	A team of care providers is wholly accountable for patient's physical and mental health care needs – includes prevention and wellness, acute care, chronic care	• Care team focuses on 'whole person' and population health • Primary care could co-locate with behavioral or oral health, vision, OB/GYN, and pharmacy • Special attention is paid to chronic disease and complex patients
Coordinated	Ensures care is organized across all elements of broader health care system, including specialty care, hospitals, home health care, community services, & public health	• Care is documented and communicated effectively across providers and institutions, including patients, primary care, specialists, hospitals, home health, etc. • Communication and connectedness is enhanced by health information technology
Accessible	Delivers consumer-friendly services with shorter wait-times, extended hours, 24/7 electronic or telephone access, and strong communication through health IT innovations	• More efficient appointment systems offer same-day or 24/7 access to care team • Use of e-communications and telemedicine provide alternatives for face-to-face visits and allow for after hours care
Committed to quality and safety	Demonstrates commitment to quality improvement through use of health IT and other tools to ensure patients and families make informed decisions	• EHRs, clinical decision support, medication management improve treatment & diagnosis. • Clinicians/staff monitor quality improvement goals and use data to track populations and their quality and cost outcomes

Potential Impacts

Patients are more likely to seek the right care, in the right place, and at the right time

Patients are less likely to seek care from the emergency room or hospital, and delay or leave conditions untreated

Providers are less likely to order duplicate tests, labs, or procedures

Better management of chronic diseases and other illness improves health outcomes

Focus on wellness and prevention reduces incidence / severity of chronic disease and illness

Cost savings result from:
- Appropriate use of medicine
- Fewer avoidable ER visits, hospitalizations, & readmissions

Source: Patient-Centered Primary Care Collaborative (2014)

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)

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

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

Regional Health Improvement Collaboratives

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5-Year Goal for Payment Innovation

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5-Year Goal for Payment Innovation

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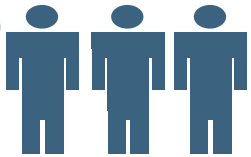
Retrospective episode model mechanics

Patients and providers continue to deliver care as they do today

1



Patients seek care and select providers as they do today

2

Providers submit claims as they do today

3

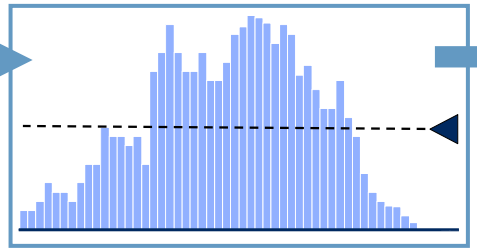
Payers reimburse for all services as they do today

Calculate incentive payments based on outcomes after close of 12 month performance period

4

Review claims from the performance period to identify a **'Principal Accountable Provider'** (PAP) for each episode

5 Payers calculate **average cost per episode** for each PAP[1]



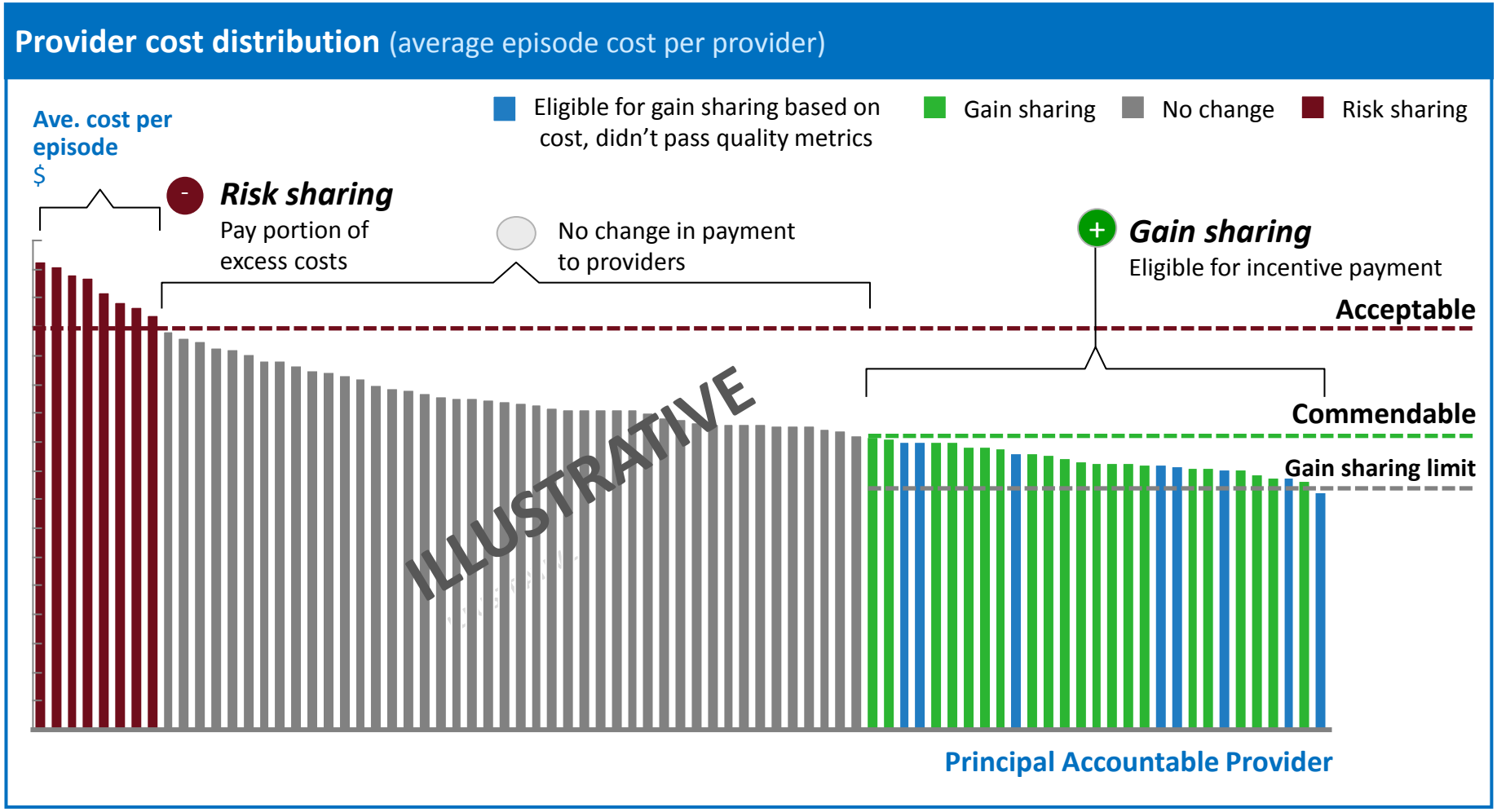
Compare average costs to predetermined ''commendable' and 'acceptable' levels[2]

6 **Providers may:**

- **Share savings**: if average costs below commendable levels and quality targets are met
- **Pay part of excess cost:** if average costs are above acceptable level
- **See no change in pay:** if average costs are between commendable and acceptable levels

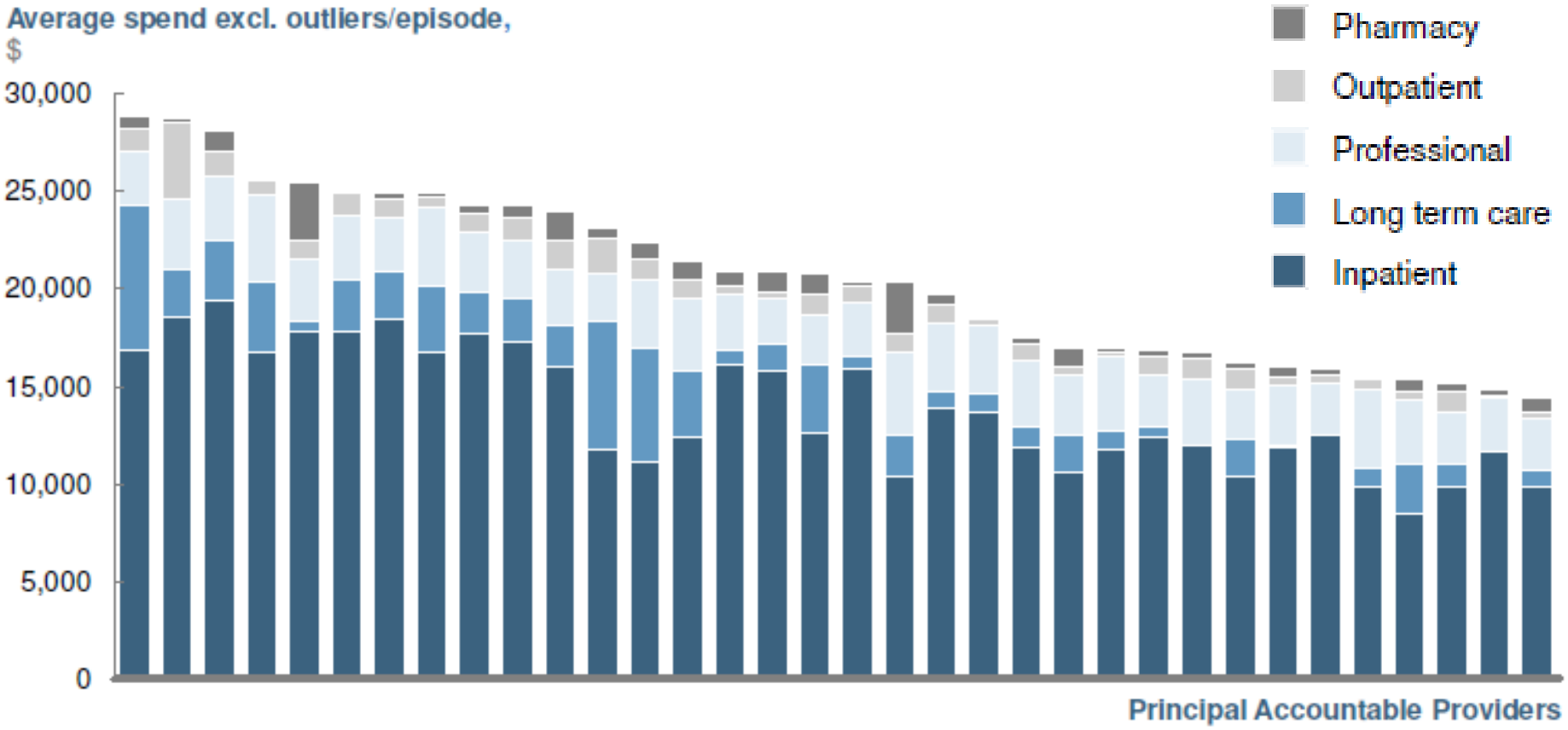
SOURCE: Arkansas Payment Improvement Initiative

Retrospective thresholds reward cost-efficient, high-quality care



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

Preliminary Provider Summary:
Total Joint Replacement Episode Distribution by Claim Type



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NOTES: Average episode spend distribution by claim type for PAPs with five or more episodes; each vertical bar represents the average spend for a PAP.
SOURCE: Analysis of Ohio Medicaid claims data, 2011-2012.

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)

This is a sample report; the actual report is under development

EPISODE of CARE PAYMENT REPORT

PERINATAL | REPORTING PERIOD: July 1st, 2013 to June 30th, 2014

PAYOR NAME : Medicaid, Ohio PROVIDER CODE : HGY28731 PROVIDER NAME : John Smith

Reporting period covering episodes that occurred between **July, 1st, 2013 and June 30th, 2014**

You would have been eligible for gain sharing of **$14,563**

Episodes inclusion and exclusion

Total: 328 Episodes

EXCLUSION
INCLUSION

29% 95 Episodes
71% 233 Episodes

Risk adjusted average cost per episode

Distribution of provider average episode cost (risk adj.)

Avg. adj. episode cost ($ '000)

Acceptable ($5,100)
Commendable ($2,400)
Gain Sharing Limit ($1,400)
You are here $2,275
Not Acceptable
Acceptable
Commendable

Episodes risk adjustment

25% of your episodes have been risk adjusted

Quality metrics

You achieved 3 of 3 quality metrics linked to gain sharing

HIV Screening	99%	✓
GBS screening	87%	✓
Chlamydia screening	90%	✓

Potential gain/risk share

If you had performed in the top quartile, your gain sharing would have been

between **$18,500** and **$53,000**

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CURRENT INITIATIVES | BUDGETS | NEWSROOM | CONTACT | VIDEO

Current Initiatives

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
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Simplify and integrate eligibility determination
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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 Test Grant Application**
- **Multi-Payer PCMH Charter**
- **Multi-Payer Episode Charter**
- **Detailed Episode Definitions**

- 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 …