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# Ohio's Health Transformation

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Governor's Office of Health Transformation

America's Health Insurance Plans
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www.HealthTransformation.Ohio.gov

| 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 in job creation (2007-2009) | | • Ranked 9th 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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## 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<br>• Eliminate fraud and abuse<br>• Prioritize home and community services<br>• Reform nursing facility payment<br>• Enhance community DD services<br>• Integrate Medicare and Medicaid benefits<br>• Rebuild community behavioral health system capacity<br>• Create health homes for people with mental illness<br>• Restructure behavioral health system financing<br>• Improve Medicaid managed care plan performance | • Create the Office of Health Transformation (2011)<br>• Implement a new Medicaid claims payment system (2011)<br>• Create a unified Medicaid budget and accounting system (2013)<br>• Create a cabinet-level Medicaid Department (July 2013)<br>• Consolidate mental health and addiction services (July 2013)<br>• Simplify and replace Ohio's 34-year-old eligibility system<br>• Coordinate programs for children<br>• Share services across local jurisdictions<br>• Recommend a permanent HHS governance structure | • Participate in Catalyst for Payment Reform<br>• Support regional payment reform initiatives<br>• Pay for value instead of volume (State Innovation Model Grant)<br>– Provide access to medical homes for most Ohioans<br>– Use episode-based payments for acute events<br>– Coordinate health information infrastructure<br>– Coordinate health sector workforce programs<br>– Report and measure system performance |

# Clear a Path for Health Plan Performance

### *Competitively rebid managed care contracts in 2012*

- Went from 7 plans in 8 regions to 5 plans statewide and increased choice from 2 or 3 plans per region to 5
- Carved in pharmacy (7/11) and added new populations, including disabled children (7/13) and dual enrollees (5/14)
- Redesigned the overall care management model to place greater emphasis on helping the most high need individuals
- Better coordination allowed rate reductions in pharmacy (12%), emergency room (8%) and inpatient hospital (1.5%) services
- Held overall program growth to 3% annually and saved Ohio taxpayers $3 billion over two years (2012-2013)

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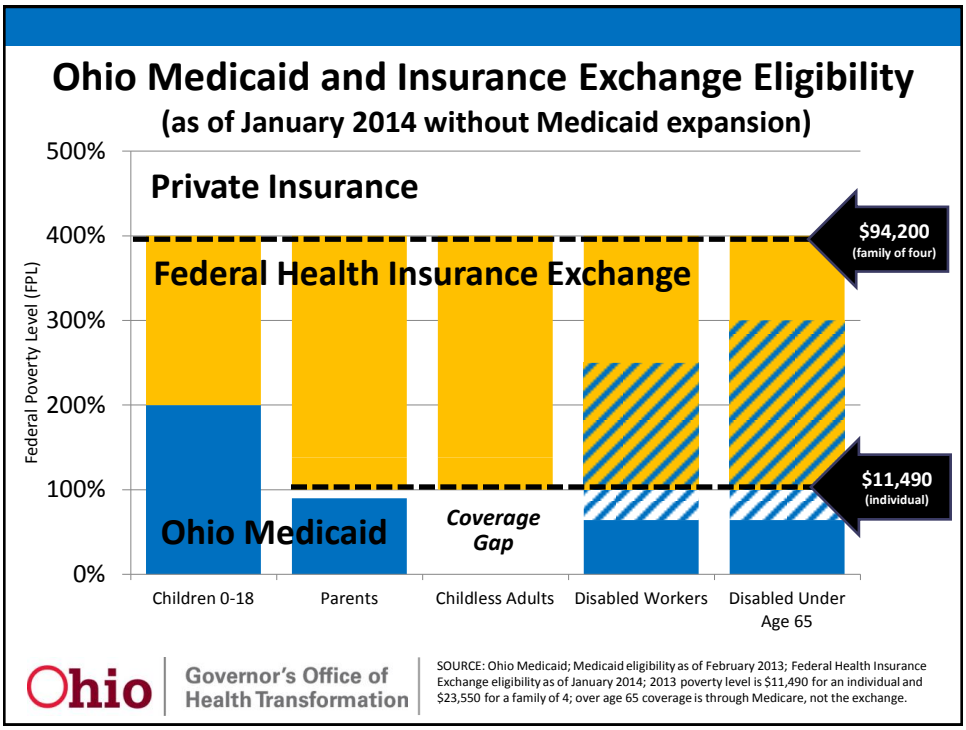
Ohio Medicaid and Insurance Exchange Eligibility
(as of January 2014 without Medicaid expansion)
500%
400%
300%
200%
100%
0%
Federal Poverty Level (FPL)
Private Insurance
Federal Health Insurance Exchange
Ohio Medicaid
Coverage Gap
$94,200
(family of four)
$11,490
(individual)
Children 0-18
Parents
Childless Adults
Disabled Workers
Disabled Under Age 65
Ohio
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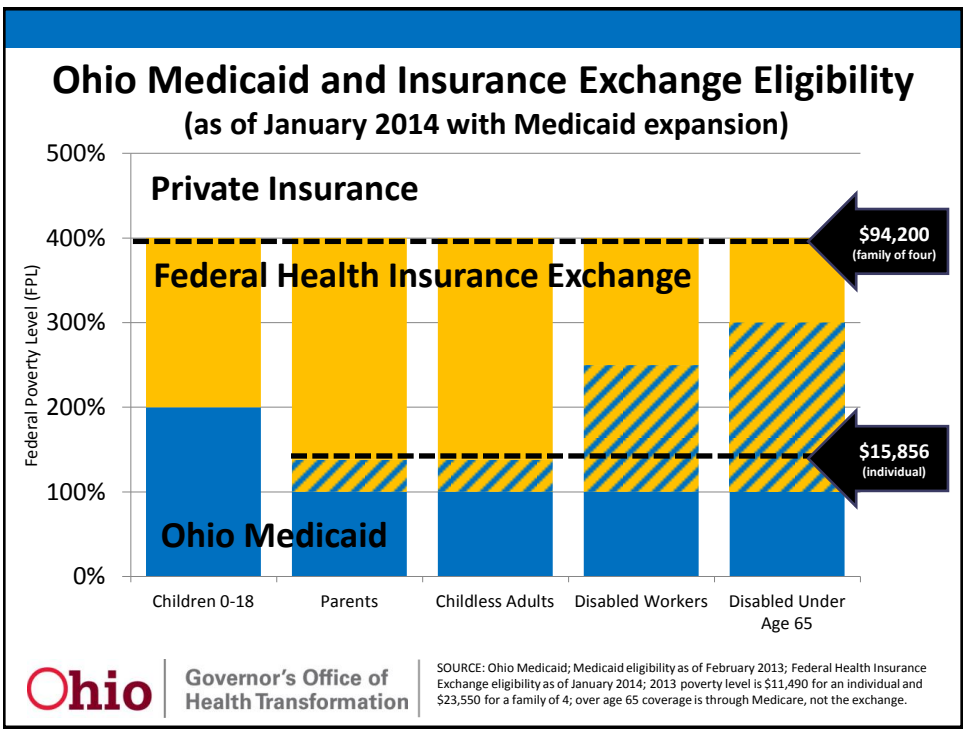
SOURCE: Ohio Medicaid; Medicaid eligibility as of February 2013; Federal Health Insurance Exchange eligibility as of January 2014; 2013 poverty level is $11,490 for an individual and $23,550 for a family of 4; over age 65 coverage is through Medicare, not the exchange.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## Ohio's State Innovation Model (SIM)

- Governor created CEO-level advisory group on payment reform (11/12)
- Ohio awarded a federal SIM design grant (2/13)
- Convened 100+ experts from 40+ organizations over 50+ meetings to align payer and provider approaches to:
  1. **Comprehensive Primary Care**, with a goal of rolling out Southwest Ohio's CMMI pilot statewide within 3 years; and
  2. **Episode-based Payments**, with a goal to launch reporting on 5 episodes in 2014 and tie to payment in 2015
- Created CPC and Episode "Charters" to align payer decisions (9/13)
- Convened Clinical Advisory Groups and posted first episode definitions for perinatal, asthma, COPD, PCI, and total joint replacement (2/14)

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## Ohio's Health Care Payment Innovation Partners:

Anthem

MEDICAL MUTUAL

aetna

UnitedHealthcare

CareSource

MOLINA HEALTHCARE

Buckeye Community Health Plan

PARAMOUNT ADVANTAGE

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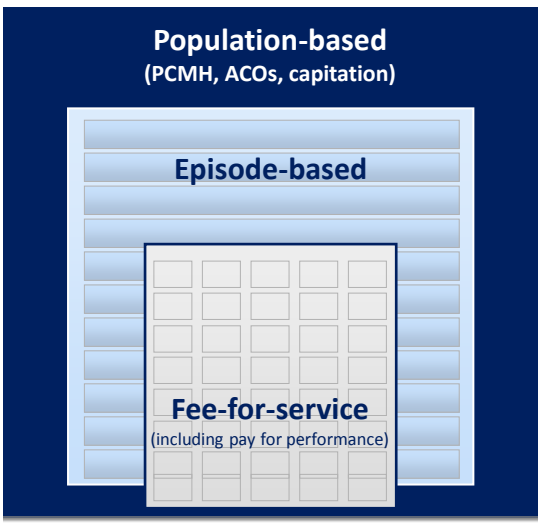
## Additional Information

1. Ohio's vision for payment innovation
2. Overview of the Patient-Centered Medical Home Model
3. Overview of the Episode-Based Payment Model

## 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)<br>▪ Payers agree to participate in design for elements where standardization and/or alignment is critical<br>▪ 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<br>▪ 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<br>▪ 50% of patients are enrolled | ▪ 20 episodes defined and launched across payers |
| **Year 5** | ▪ Scale achieved state-wide<br>▪ 80% of patients are enrolled | ▪ 50+ episodes defined and launched across payers |

## Agree on degrees of standardization within each model

### "Standardize approach"

Standardize approach (i.e., identical design) only when:

- Alignment is critical to provider success or significantly eases implementation for providers (e.g., lower administrative burden)
- Meaningful economies of scale exist
- Standardization does not diminish potential sources of competitive advantage among payers
- It is lawful to do so
- In best interest of patients (i.e., clear evidence base)

### "Align in principle"

Align in principle but allow for payer innovation consistent with those principles when:

- There are benefits for the integrity of the program for payers to align
- It benefits providers to understand where payers are moving in same direction; it's beneficial to know payers are not moving in different direction
- Differences have modest impact on provider from an administrative standpoint
- Differences are necessary to account for legitimate differences among payers (e.g., varied customers, members, strategy, administrative systems)

### "Differ by design"

Differ by design when:

- Required by laws or regulations
- An area of the model is substantially tied to competitive advantage
- There exists meaningful opportunity for innovation or experimentation

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# Elements of a Patient-Centered Medical Home Strategy

| | | |
|---|---|---|
| **Care delivery model** | Target patients and scope<br>Care delivery improvements e.g.,<br>▪ Improved access<br>▪ Patient engagement<br>▪ Population management<br>▪ Team-based care, care coordination<br>Target sources of value | Vision for a PCMH's role in the healthcare eco system, including who they should target, how care should be delivered (including differences from today), and which sources of value to prioritize over time. |
| **Payment model** | Technical requirements for PCMH<br>Attribution / assignment<br>Quality measures<br>Payment streams/ incentives<br>Patient incentives | Holistic approach to use payment (from payers) to encourage the creation of PCMHs, ensure adequate resources to fund transformation from today's model, and reward PCMH's for improving in outcomes and total cost of care over time |
| **Infrastructure** | PCMH infrastructure<br>Payer infrastructure<br>Payer / PCMH infrastructure<br>PCMH/ Provider infrastructure<br>System infrastructure | Technology, data, systems, and people required to enable creation of PCMH, administer new payment models, and support PCMHs in making desired changes in care delivery |
| **Scale-up and practice performance improvement** | Clinical leadership / support<br>Practice transformation support<br>Workforce / human capital<br>Legal / regulatory environment<br>Network / contracting to increase participation<br>ASO contracting/participation<br>Performance transparency<br>Ongoing PCMH support<br>Evidence, pathways, & research<br>Multi-payer collaboration | Support, resources, or activities to enable practices to adopt the PCMH delivery model, sustain transformation and maximize impact |

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# Elements of an Episode-Based Payment Strategy

| | Program-level design decisions | Episode-specific design decisions |
|---|---|---|
| **Participation** | Provider participation<br>Payer participation<br>} Related to 'scale-up' plan for episodes | |
| **Account-ability** | Providers at risk – Number<br>Providers at risk – Type of provider(s)<br>Providers at risk – Unique providers<br>Cost normalization approach | |
| **Payment model mechanics** | Prospective or retrospective model<br>Risk-sharing agreement – types of incentives<br>Approach to small case volume<br>Role of quality metrics<br>Provider stop-loss<br>Absolute vs. relative performance rewards | |
| **Performance management** | Absolute performance rewards – Gain sharing limit<br>Approach to risk adjustment<br>Exclusions | |
| **Payment model timing** | Preparatory/"reporting-only" period<br>Length of "performance" period<br>Synchronization of performance periods | |
| **Payment model thresholds** | Approach to thresholds<br>How thresholds change over time<br>Specific threshold levels<br>Degree of gain / risk sharing<br>Cost outliers | |
| **Core Episode definition** | | Quarterback selection<br>Triggers<br>Episode timeframe – Type/length of pre-procedure/ event window<br>Claims in- or excluded: pre-procedure/event window<br>Claims in- or excluded: during procedure/event<br>Claims in- or excluded: post procedure/event (incl. readmission policy) |
| **Episode cost adjustment** | | Risk adjustors<br>Unit cost normalization - Inpatient<br>Unit cost normalization - Other<br>Adjustments for provider access<br>Approach to cost-based providers<br>Clinical exclusions |
| **Quality metric selection** | | Approach to non-claims-based quality metrics<br>Quality metric sampling<br>Quality metrics linked to payment<br>Quality metrics for reporting only |

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# Retrospective episode model mechanics

**Patients and providers continue to deliver care as they do today**

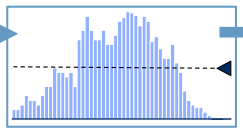
1. **Patients** seek care and select providers as they do today
2. **Providers** submit claims as they do today


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]



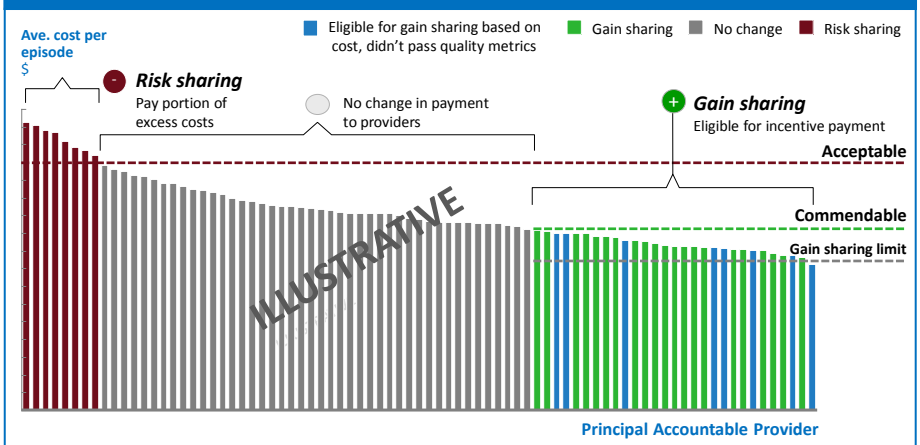
**Compare average costs** to predetermined ''commendable' and 'acceptable' levels[2]

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

**Provider cost distribution** (average episode cost per provider)

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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

# Episode Algorithm Design Elements

Identify trigger and episode spend → Identify Primary Accountable Provider (PAP) → Remove Exclusions → Apply Risk Adjustment → Assess Quality Metrics

***Example: Asthma Acute Exacerbation***

- *Trigger*
  - ED visit
  - IP admission
- *Pre-Trigger (none)*
- *Post-Trigger (30 days) includes relevant:*
  - Office visits
  - Labs
  - Medications
  - Readmissions
- ED facility or admitting facility
- Specific comorbidities
- Use of a vent
- ICU more than 72 hours
- Left AMA
- Death in hospital
- Under 5 years old
- Eligibility
- 9 risk factors
- Uses coefficients from AR model
- *Linked to gain sharing:*
  - Corticosteroid and/or inhaled corticosteroid use
  - Follow-up visit within 30 days
- *For reporting:*
  - Repeat acute exacerbation rate

**Each episode algorithm is jointly developed with input from key stakeholders including providers (e.g., pulmonologists in this example) and payers**

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# Where we are in the episode design process

| Episode design path | Design of overall model for the State Health Improvement Plan | Episode definitions | Payer specific episode design decisions |
|---|---|---|---|
| | Multi-payer agreement or 'charter'<br>Medicaid 'strawman' | Perinatal<br>Asthma/COPD exacerbation<br>PCI<br>Joint replacement | Customization and Performance Thresholds |
| **Description** | ▪ Agreement on decisions for multi-payer alignment<br>▪ Working hypothesis for Medicaid; share w/ payers | ▪ Clinical input on elements of episode definition (e.g., principal accountable provider) | ▪ Work through payer specific elements (e.g., cost normalization) |
| **Who's involved?** | ▪ Multi-payer Core team<br>▪ Payer / provider episode design group | ▪ Clinical Advisory Group<br>▪ SIM Core team aligns on final definitions | ▪ Internal state episode design team<br>▪ Individual payer design teams |
| **Outputs** | ▪ Charter<br>▪ 3 – 5 year vision | ▪ Detailed business requirements for each episode (e.g., code sets) | ▪ Payer-specific episode algorithms |

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Note: as of March 1, 2014.