Ohio | Governor's Office of Health Transformation

Inevitable Transformation: How Health Care Delivery is Changing

Greg Moody, Director
Office of Health Transformation

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www.HealthTransformation.Ohio.gov

The Bureau of Worker's Compensation is one program among many within the health care system

Many of the challenges BWC faces exist in the health care system overall, not just BWC

It is important to understand the overall challenges and trends to identify opportunities

BWC can leverage its purchasing power to improve overall health system performance


Oh, crap! Was that TODAY?
REGAN

Agenda

1. **Health System Challenges**
2. Health System Trends
3. Better Coordination
4. Pay for Value

INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES

Facing the Evidence on Quality

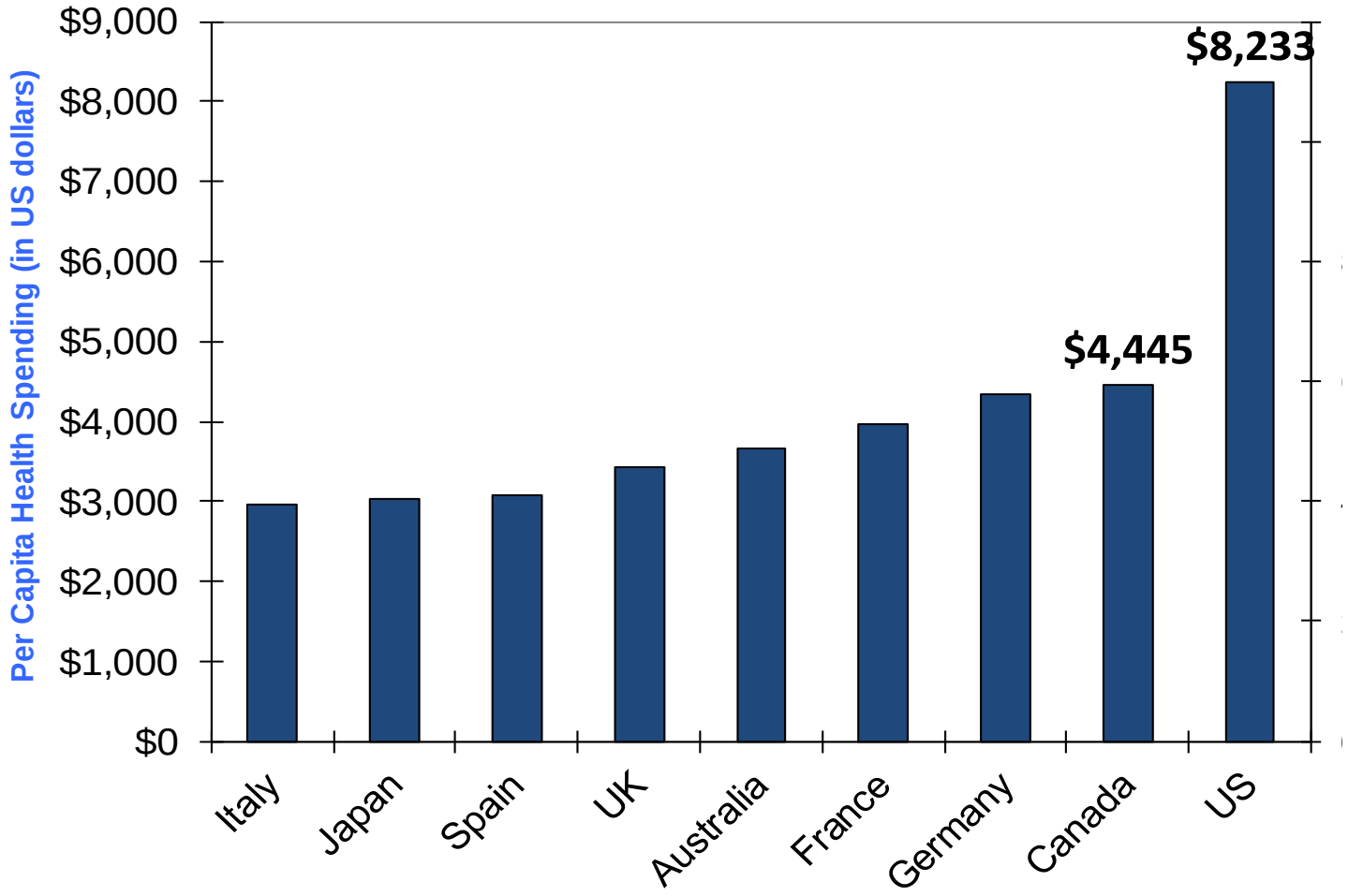
- **Not safe** – Between one-fifth and one-third of hospital patients are harmed during their stay and much of that harm is preventable (IOM 2012)
- **Not timely** – The U.S. ranks last among 19 industrial nations related to preventable deaths with timely and effective care (Commonwealth 2008)
- **Not effective** – Americans receive only 55% of recommended treatments for preventive care, acute care, and chronic care management (NEJM 2003)
- **Not efficient** – Nearly 30% of all health care spending is wasted, much of it on unnecessary or inefficiently delivered services (IOM 2009)
- **Not patient-centered** – Half of all Americans feel their doctor does not spend enough time with them (Commonwealth 2005)
- **Not equitable** – racial and ethnic minorities receive care that often is of lower quality compared to the care received by whites (NEJM 2004)

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)

Health Spending Per Capita by Country (2012)



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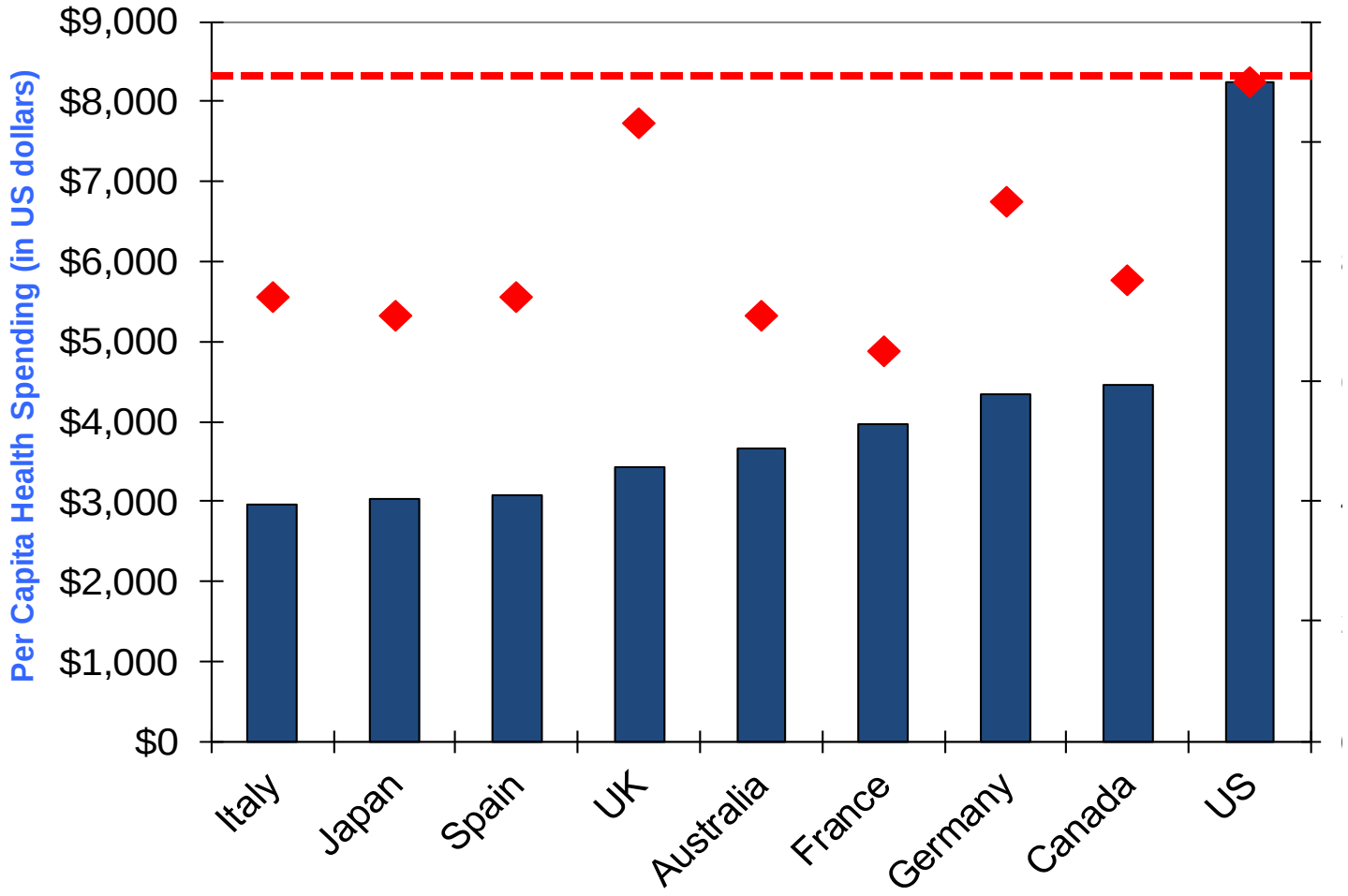
Source: OECD Health Data 2012; Nolte and McKee, "Measuring the Health of Nations: Updating an Earlier Analysis," Health Affairs (January 2008)

Health Spending Per Capita by Country (2012) and Preventable Deaths with Appropriate Care (2003)



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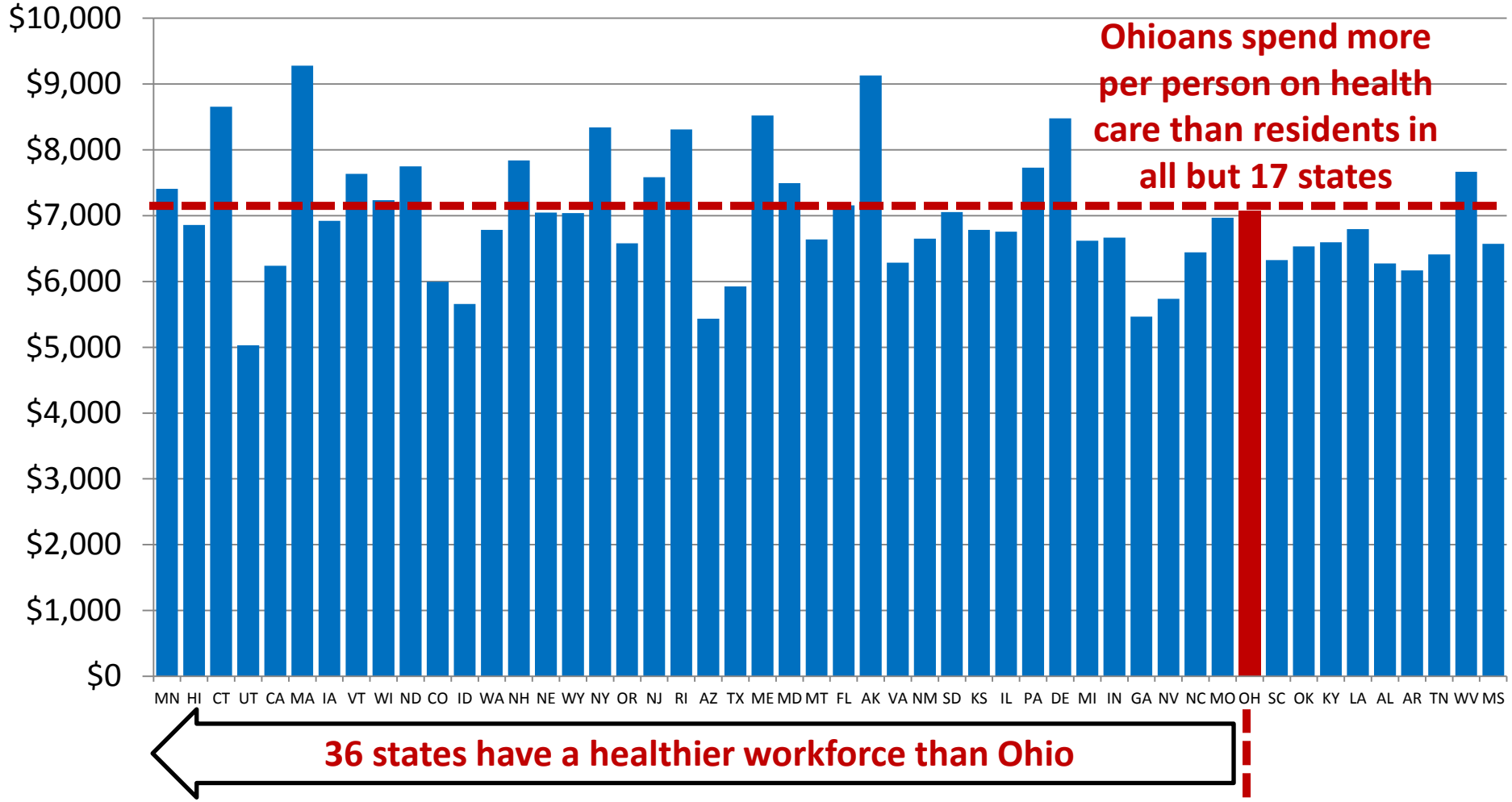
Source: OECD Health Data 2012; Nolte and McKee, "Measuring the Health of Nations: Updating an Earlier Analysis," Health Affairs (January 2008)

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



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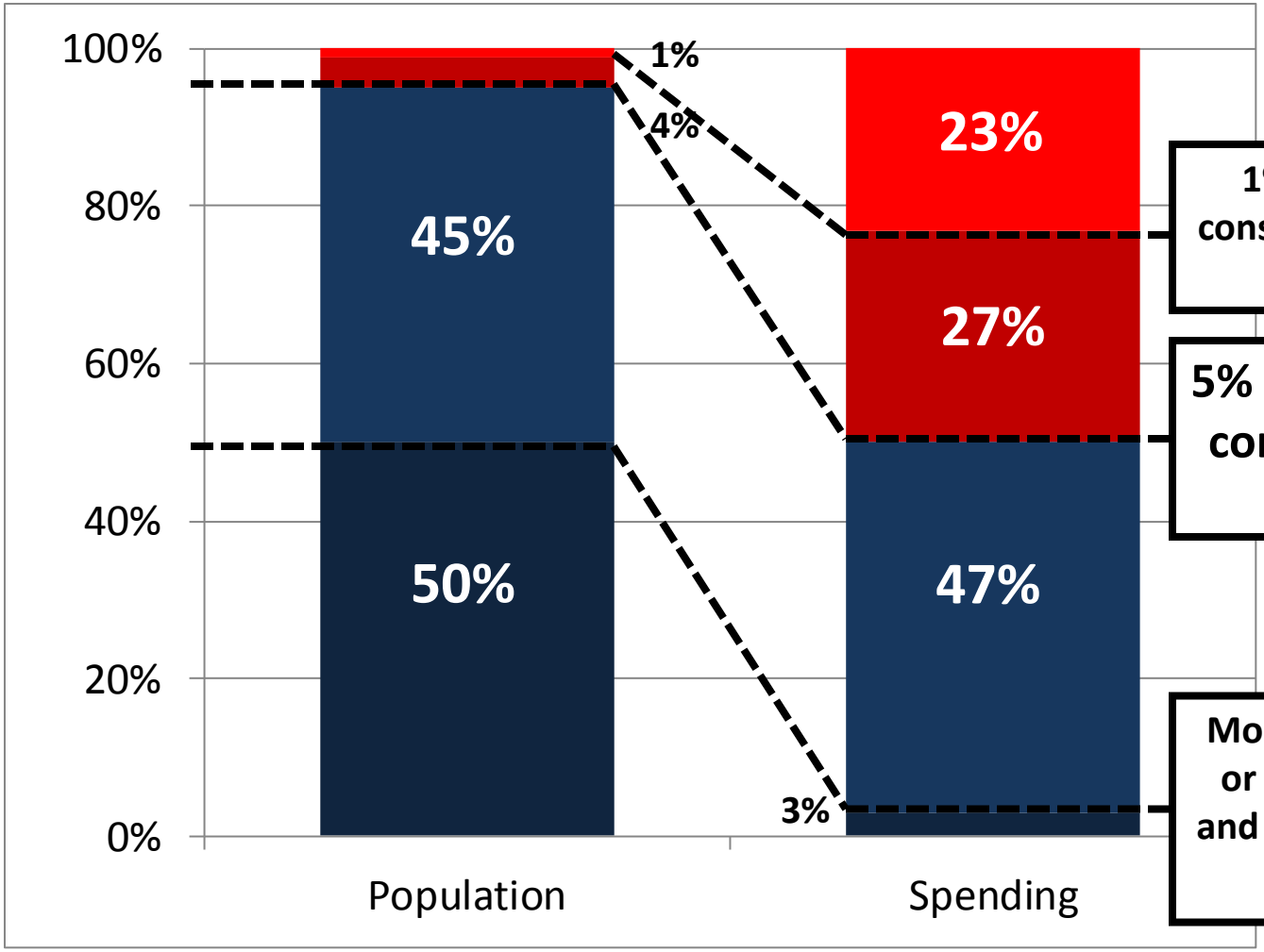
Sources: CMS *Health Expenditures by State of Residence* (2011); The Commonwealth Fund, *Aiming Higher: Results from a State Scorecard on Health System Performance* (October 2009).

A few high-cost cases account for most health spending



1% of the US population consumes 23% of total health spending

5% of the US population consumes 50% of total health spending

Most people (50%) have few or no health care expenses and consume only 3% of total health spending

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Source: Kaiser Family Foundation calculations using data from AHRQ Medical Expenditure Panel Survey (MEPS), 2007

Health Care System Today

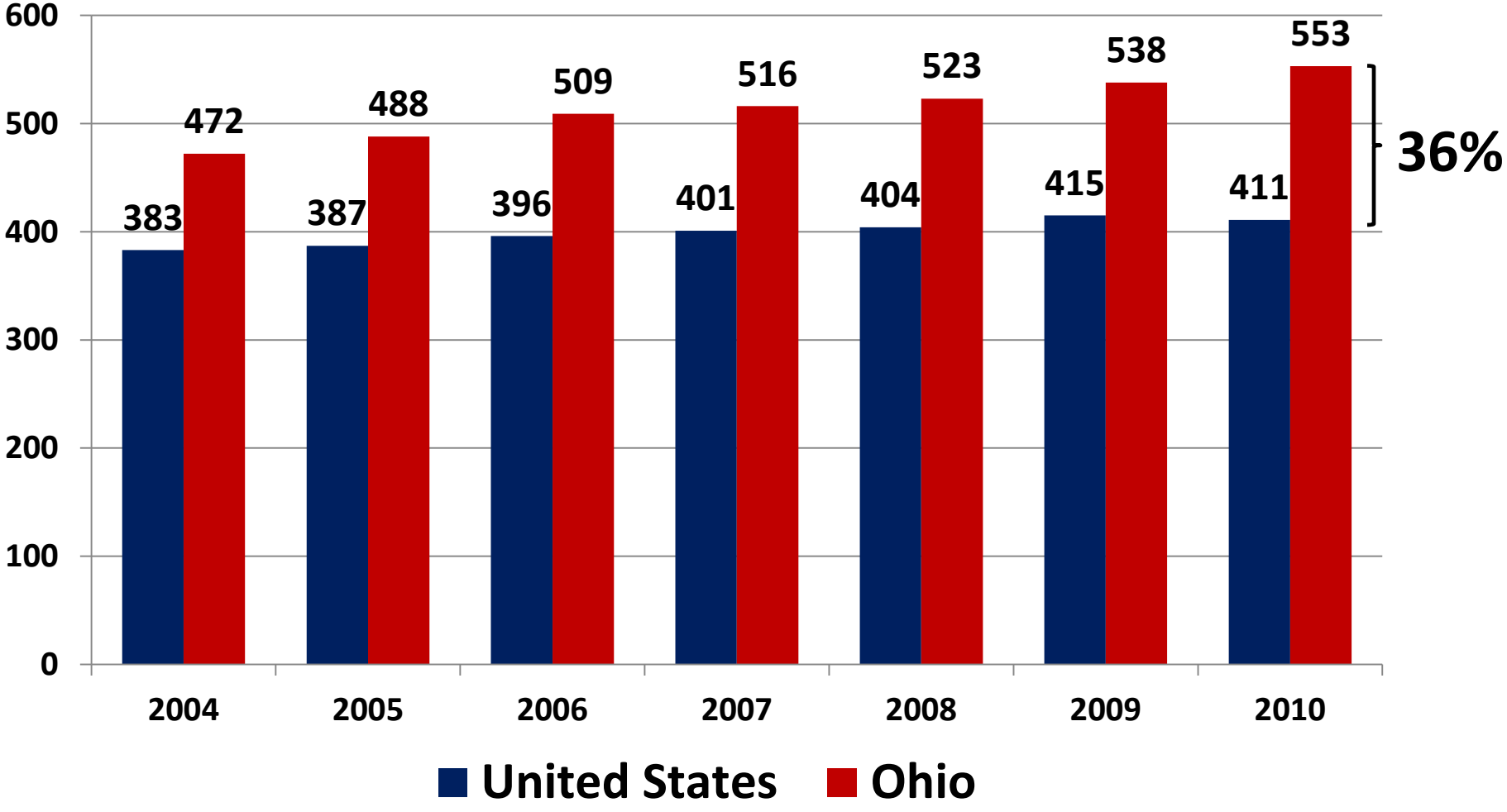
Fragmentation

- Multiple separate providers
- Provider-centered care
- Reimbursement rewards volume
- Lack of comparison data
- Outdated information technology
- No accountability
- Institutional bias
- Separate government systems
- Complicated categorical eligibility
- Rapid cost growth

SOURCE: Adapted from Melanie Bella, *State Innovative Programs for Dual Eligibles*, NASMD (November 2009)

Emergency Department Utilization: Ohio vs. US

Hospital Emergency Room Visits per 1,000 Population



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Source: American Hospital Association Annual Survey (April 2012) and population data from Annual Population Estimates, US Census Bureau.

Per Capita Health Spending: Ohio vs. US

Measurement	US	Ohio	Percentage Difference	Affordability Rank (Out of 50 States)
Total Health Spending	**$6,815**	**$7,076**	**+3.8%**	**33**
Hospital Care	$2,475	$2,881	+16.4%	36
Physician/Clinical	$1,650	$1,456	-11.8%	12
Nursing Home Care	$447	$610	+36.5%	43
Home Health Care	$223	$223	--	38

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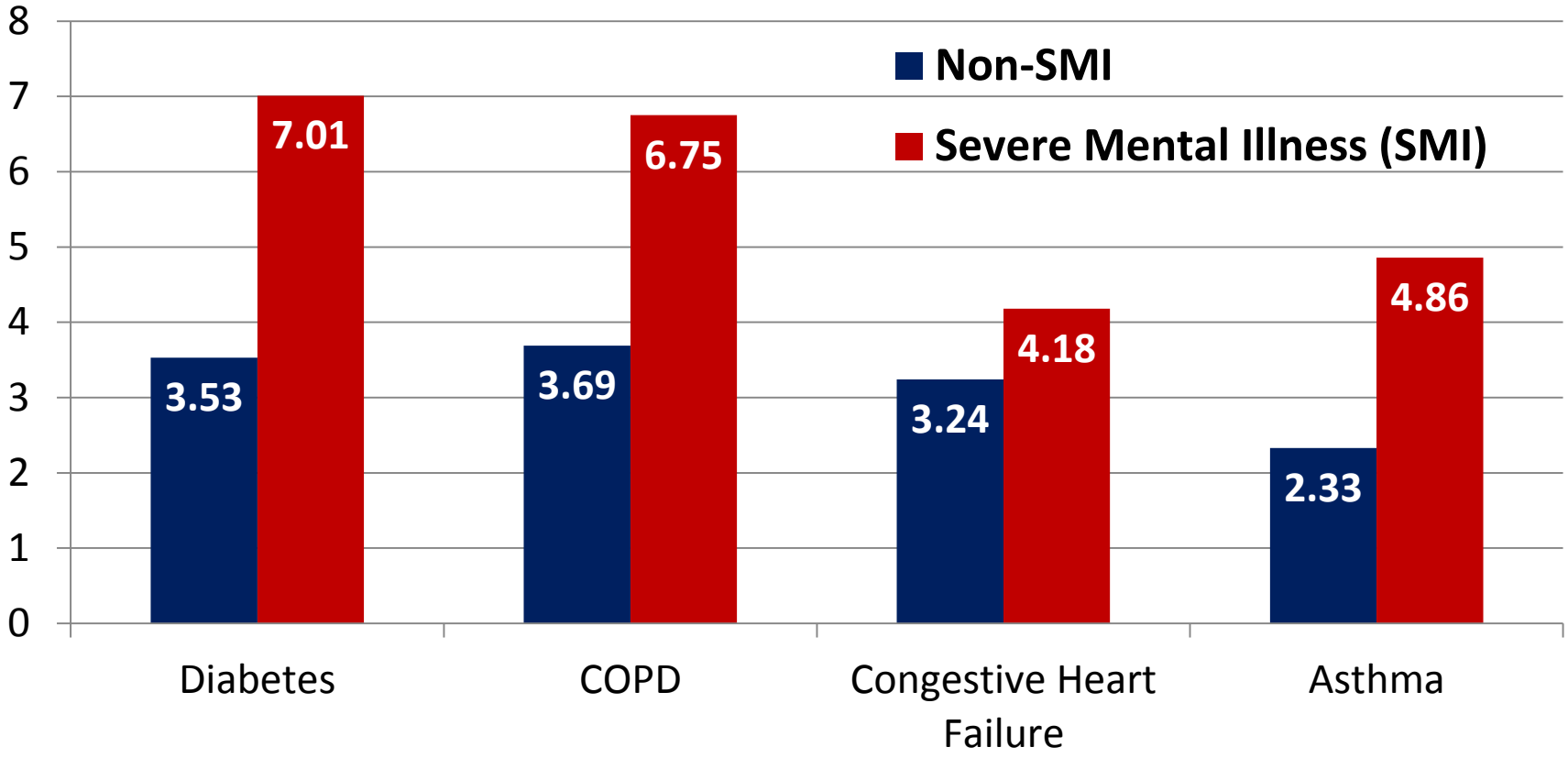
Source: 2009 Health Expenditure Data, Health Expenditures by State of Residence, Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, released December 2011; available at http://www.cms.gov/NationalHealthExpendData/downloads/resident-state-estimates.zip

Hospital Admissions for People with Severe Mental Illness

Avoidable hospitalizations per 1000 persons for ambulatory care sensitive conditions (avoidable with proper treatment)



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Source: Ohio Colleges of Medicine Government Resource Center and Health Management Associates, Ohio Medicaid Claims Analysis (February 2011)

Health Care System Today

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Health Care System Choices

Fragmentation	vs.	Coordination
• Multiple separate providers		• Accountable medical home
• Provider-centered care		• Patient-centered care
• Reimbursement rewards volume		• Reimbursement rewards value
• Lack of comparison data		• Price and quality transparency
• Outdated information technology		• Electronic information exchange
• No accountability		• Performance measures
• Institutional bias		• Continuum of care
• Separate government systems		• Medicare/Medicaid/Exchanges
• Complicated categorical eligibility		• Streamlined income eligibility
• Rapid cost growth		• Sustainable growth over time

SOURCE: Adapted from Melanie Bella, *State Innovative Programs for Dual Eligibles*, NASMD (November 2009)

Agenda

1. Health System Challenges
2. **Health System Trends**
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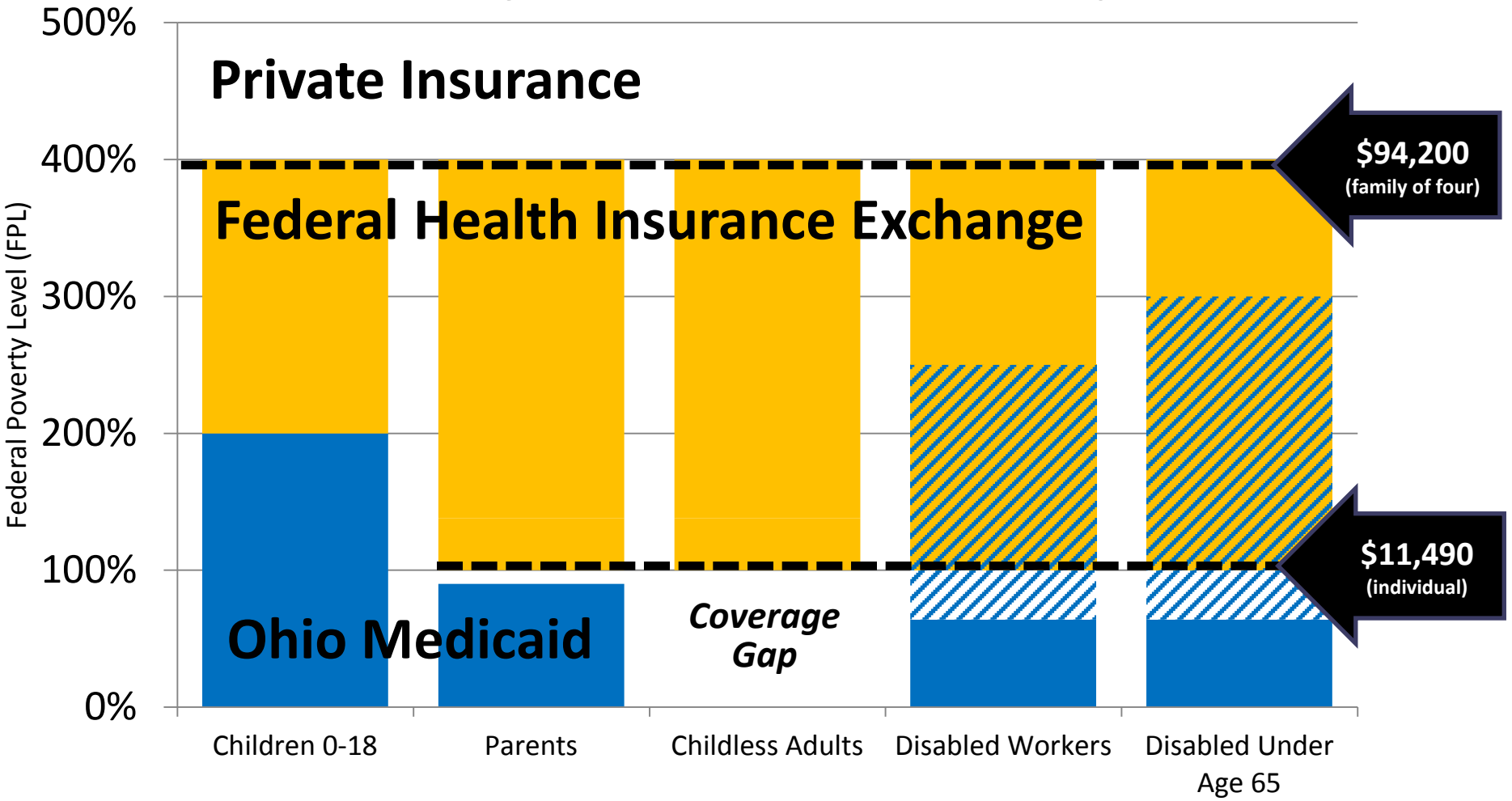
2010 Affordable Care Act Changes

- **Mainstream Coverage** – insurance reforms, individual and business mandates, subsidized exchanges, extend Medicaid coverage
- **Delivery System Reform** – patient-centered, payment reform, integrated services; care coordination, prevention/primary care
- **Provider Capacity** – increase reimbursement, workforce planning and development, population health focus
- **Increase Transparency** – evidence-based, minimize practice variation, accelerate HIT/HIE adoption

Ohio Medicaid and Insurance Exchange Eligibility

(as of January 2014 without Medicaid expansion)



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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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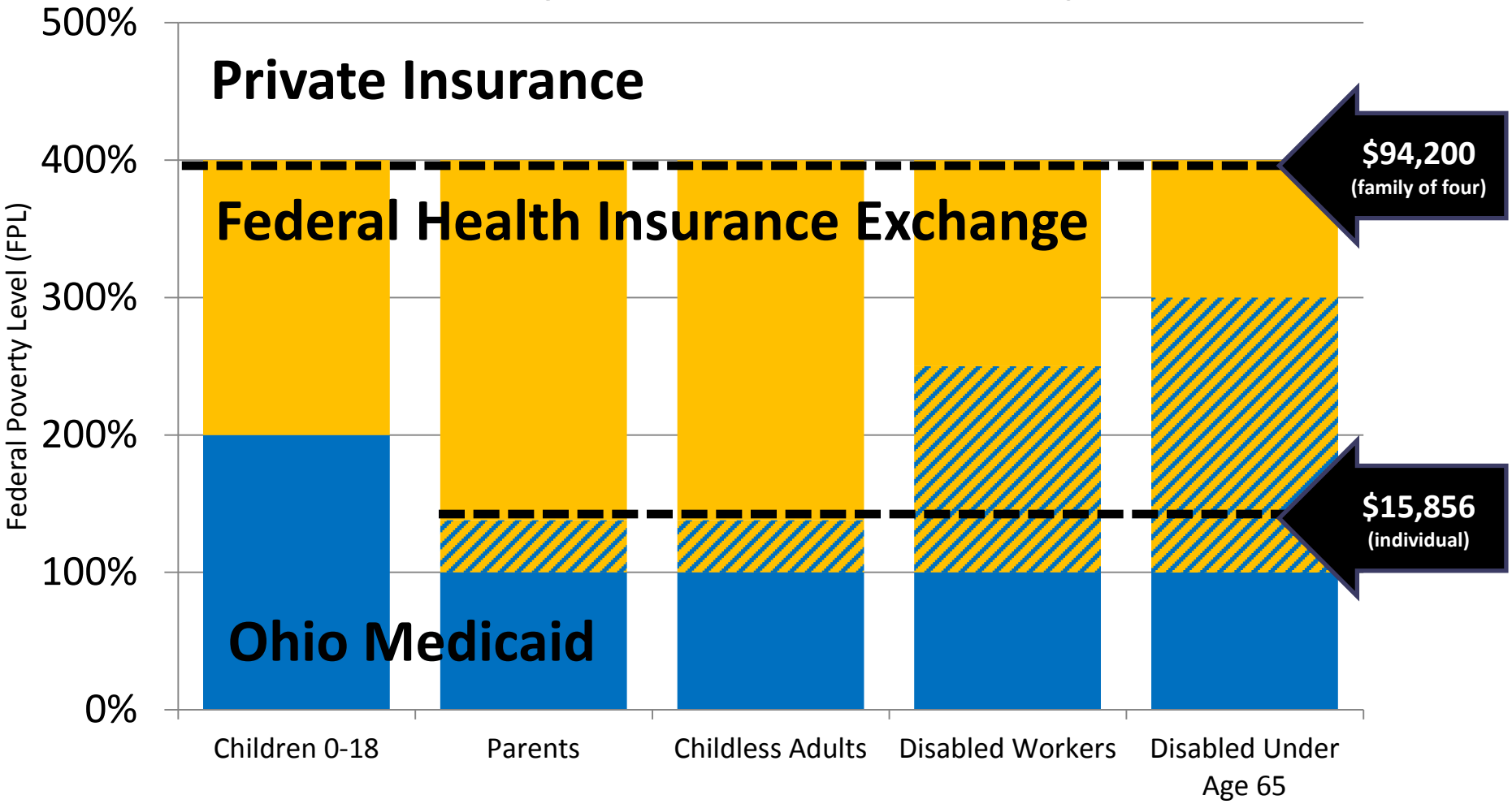

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SOURCE: Ohio Medicaid; Medicaid eligibility as of February 2013; Federal Health Insurance Exchange eligibility as of January 2014; 2013 poverty level is $11,490 for an individual and $23,550 for a family of 4; over age 65 coverage is through Medicare, not the exchange.

Health Plan/MCO Participation in Ohio Markets

Plan	BWC	Medicaid	Medicare-Medicaid	Federal Exchange	Commercial
Anthem				X	X
Aetna			X		X
United		X	X		X
Medical Mutual				X	X
Buckeye		X	X	X	
Molina		X	X	X	
CareSource		X	X	X	
Paramount	X	X		X	X
AultCare	X			X	X
CareWorks	X				
CompManagement	X				
OHIOCOMP	X				
Sheakley Unicomp	X				
10 plans < 1,000 policies	X				

Health Care Payment and Delivery System Trends

- Payer mix and provider networks changing as a result of ACA insurance mandates, Medicaid expansion, and new Exchanges
- New care and payment models will continue to develop and expand, and require scale and sophistication to implement
- Consolidation of providers will continue and accelerate, and health systems will continue to expand their continuum of care
- Physician shortage begins to take effect, ironically as the demand for enhanced primary care increases
- Data transparency will continue to increase and drive innovation, revealing “hot spots” as opportunities for better coordination

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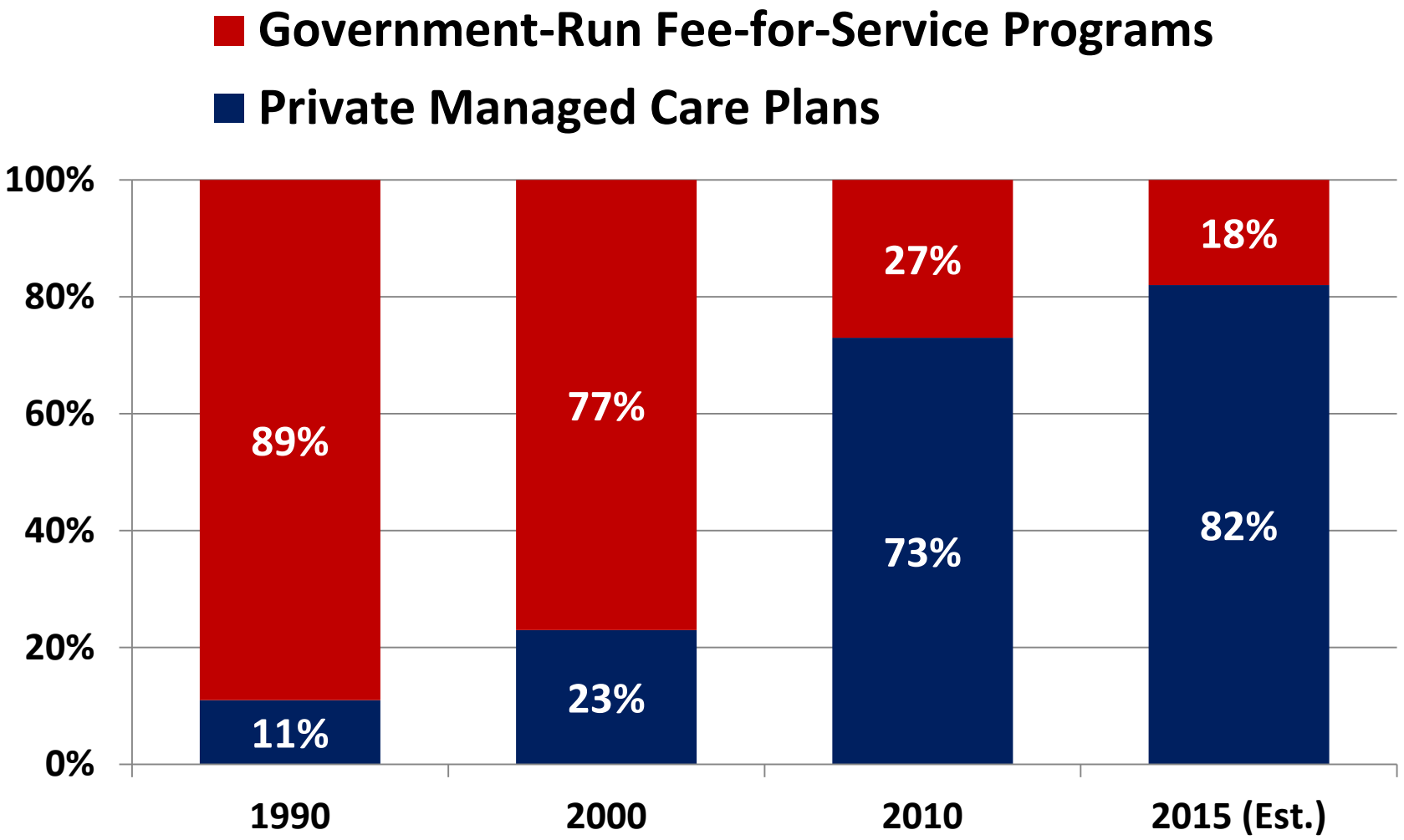
Ohio Medicaid Increasingly Relies on Managed Care



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Source: Ohio Medicaid (2013); 2015 Executive Budget as proposed.

Hallmarks of a Meaningful Managed Care System

- Provide health benefits to a defined population for a fixed payment
- Explicit standards for selecting a network of providers
- Formal utilization review and quality improvement programs
- Emphasis on keeping enrollees healthy to reduce use of services
- Require preauthorization for visits to specialists
- Financial incentives to encourage enrollees to use care efficiently

Ohio Medicaid Managed Care

Reforms:

- Went from 7 plans in 8 regions to 5 plans statewide
- Increased choice for enrollees from 2 to 3 plans per region to 5
- Tiered case management to focus on greatest need
- Focused on reducing preventable emergency room use

Results:

- Cut administrative rates 1% in 2011 and another 1% in 2013
- Decreased emergency department use (8%), inpatient hospital costs (1.5%), and pharmacy costs (12%)
- Saved Ohio taxpayers $144 million in 2011, $646 million in 2013

Comparing Ohio's Care Management Systems

	Ohio Medicaid	Ohio Bureau of Workers' Compensation
Number of plans	5	16
Annual medical spending (SFY 2013)	$19.8 billion	$706 million
Risk model	Capitated, full risk managed care organization	Administrative service organization
Consumer choice	Choice of plan guaranteed	Choice of provider guaranteed

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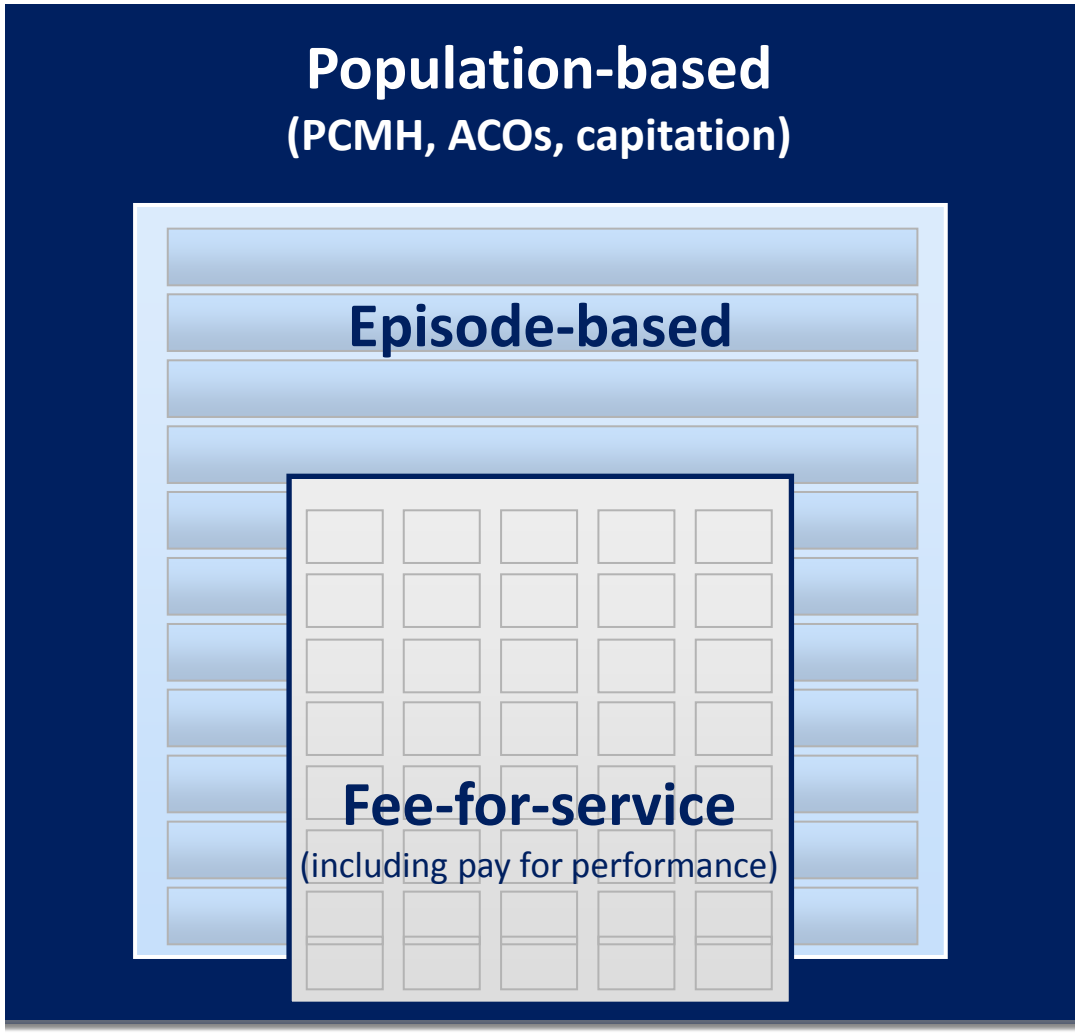
Shift to population-based and episode-based payment

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:

Anthem

MEDICAL MUTUAL

aetna

UnitedHealthcare

CareSource

MOLINA HEALTHCARE

Buckeye Community Health Plan

PARAMOUNT ADVANTAGE

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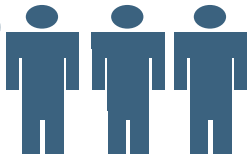
Retrospective episode model mechanics

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 

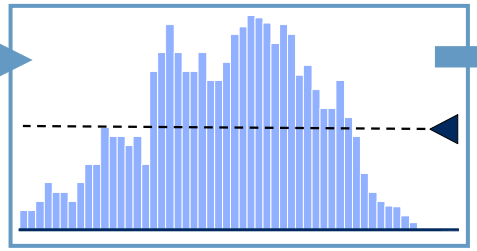
Payers reimburse for all services as they do today

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]

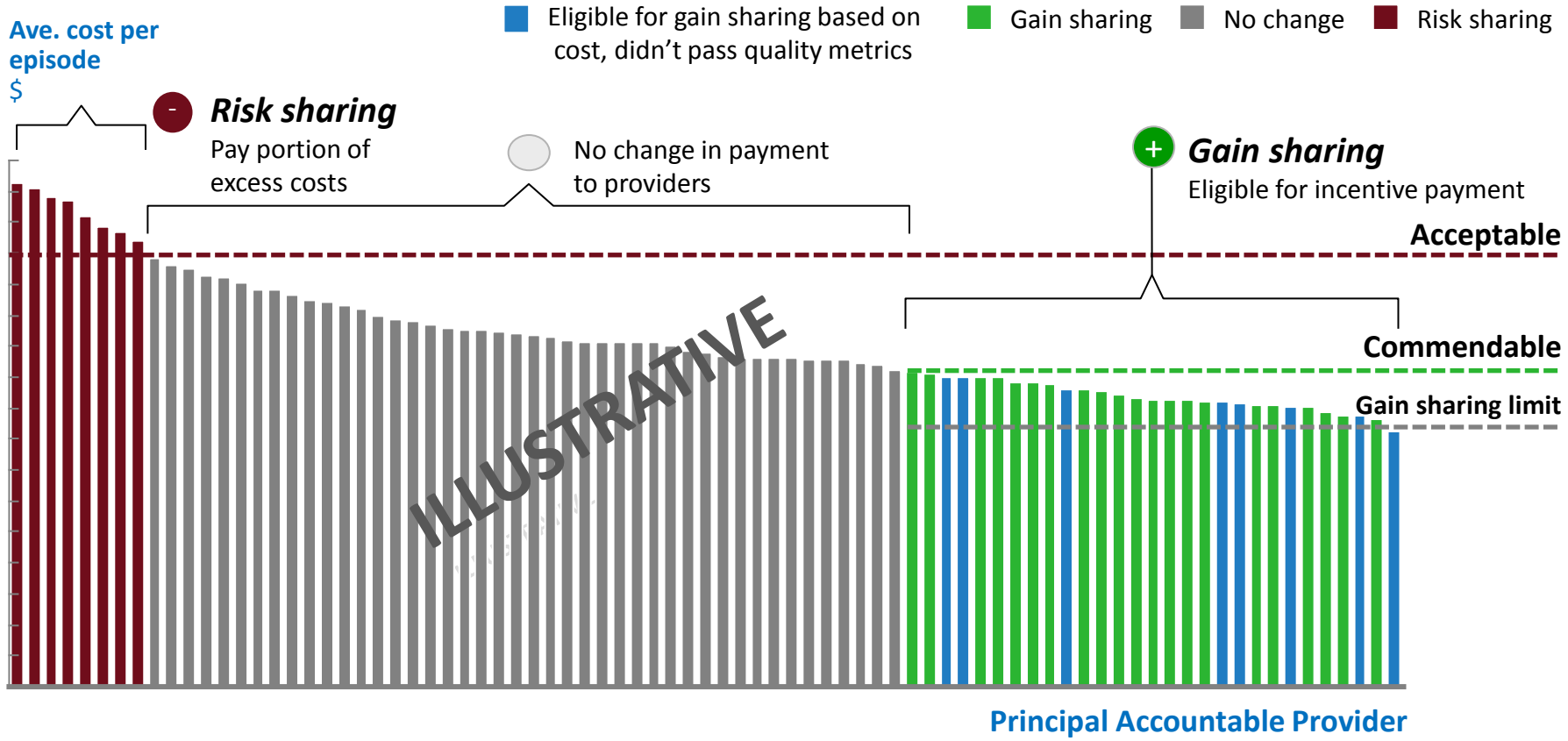
6 **Providers may:**

- **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

Patient Journey: Total Joint Replacement

Patient suffers from limited joint functionality

Initial assessment by surgeon or other orthopedic physician

- Appropriateness (e.g., medical, social, BMI, suitability of risk, timing)
- Objective evidence (e.g., x-ray imaging)

Pre-surgical care

- Patient receives further diagnostic testing/labs, medications, and consultation (e.g., cardiologist, PCP, comorbidity management, rehab planning, education) as needed

Potential episode trigger event:

Surgery

- Patient receives a hip or knee implant to replace non-functioning joint
- Surgery is performed in either an outpatient or inpatient setting
  - Factors influencing quality include: surgery time, anesthesia and wound closure (e.g., staples, stitches, glue)
  - Sources of variation include: implant choice, length of stay, medications prescribed

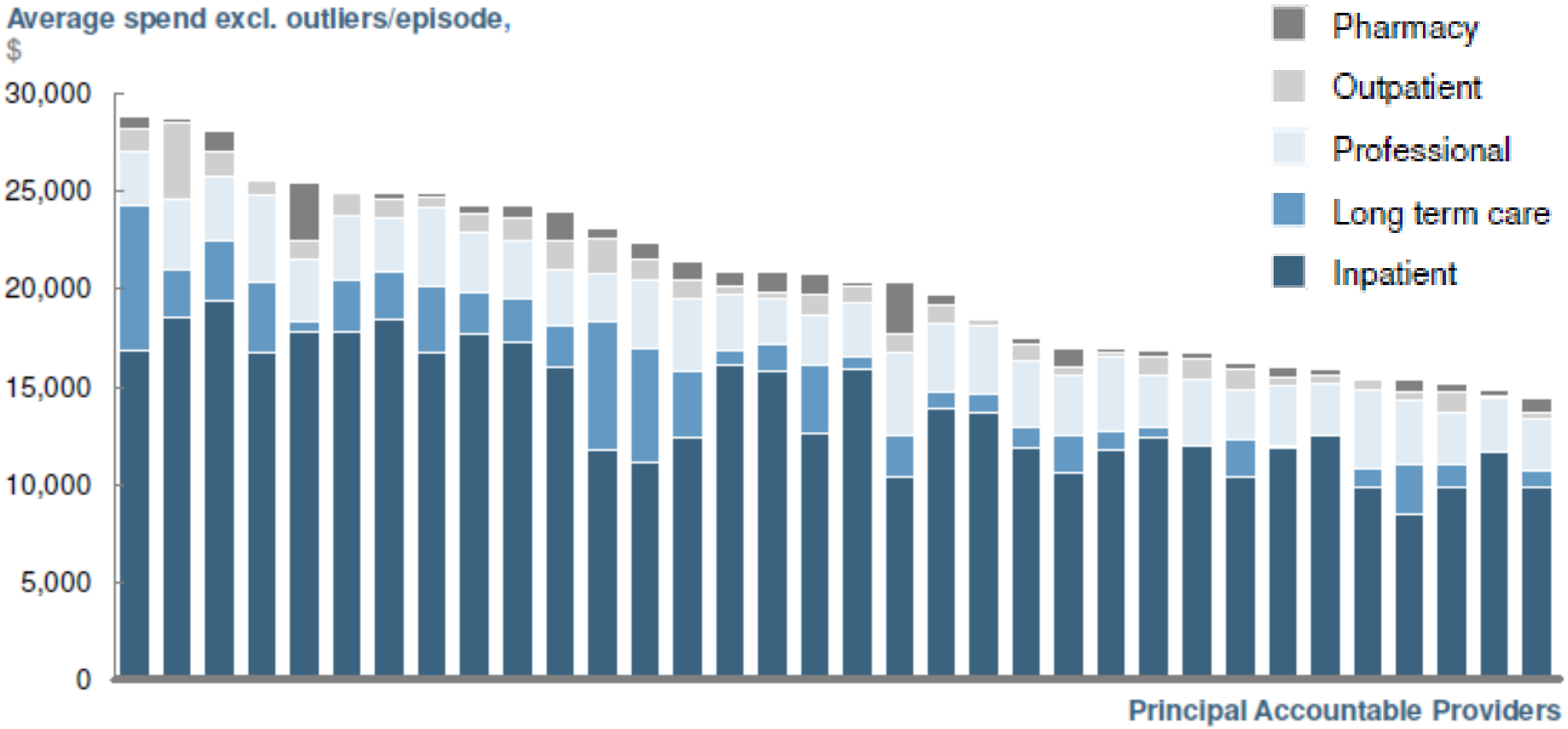
Follow-up care

- Patient receives rehabilitation support in a skilled nursing facility or at home with physical therapy and home health
- Medications to alleviate pain are prescribed

Potential complications (e.g., revision, DVT, PE, infection, mechanical complications)

SOURCE: Clinical experts, team analysis.

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.

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Patient Journey and Sources of Value: Total Joint Replacement

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A *Appropriate pre-surgical care (e.g., imaging utilization, cardiac and other surgical risk assessment)*

- diagnostic testing/labs, medications, and consultation (e.g., cardiologist, PCP, comorbidity management, rehab planning, education) as needed

Surgery

- Pa… or …

B *Decisions related to procedure (e.g., facility choice, anaesthesia, implant selection)*

- …gery time, anesthesia and wound closure (e.g., staples, stitches, glue)
- Sources of variation …oice, …ribed

C *Appropriate length of inpatient stay*

Follow-up care

- Patient receives rehabilitation support in a skilled nursing facility or at home with phy… h…e
- Me… …ain are prescribed

D *Proper recovery / rehabilitation treatment*

Potential complications (e.g., revision, DVT, PE, infection, mechanical complications)

E *Reduction of readmissions and complications*

SOURCE: Clinical experts, team analysis.

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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
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