Transforming Payment for a Healthier Ohio

June 8, 2014

• 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 ...

[Ohio's Innovation Model]

[Website: www.healthtransformation.ohio.gov]
1. Ohio Approach to Paying for Value Instead of Volume
2. Patient-Centered Medical Home Model
3. Episode-Based Payment Model
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)
Ohio is one of 16 states that received a CMS State Innovation Model design grant in 2013 – grants provided $1-3M for a state-led, multi-stakeholder effort to develop a State Health Innovation Plan.

Ohio also is one of seven states chosen to implement a comprehensive primary care initiative to foster collaboration among public and private health care payers to strengthen primary care. Medicare will work with commercial and state health insurance plans and offer bonus payments to primary care doctors who better coordinate care for their patients.

6 states also received State Innovation Model testing grants of $20-60M to implement their innovation plans over 3-5 years.

On May 22, 2014, CMS announced a new rounds of funding opportunities for State Innovation Models. $700M will be available to up to 12 states for Model Testing, and $30M for up to 15 more states for Model Design. Ohio will be applying for Model Testing.

Applications are due 7/21, expect funding decisions to be announced end of October, with funding to start January of 2015, to last for 4 years.
Ohio is ahead of the curve in health care innovation, and has an opportunity to shape how these models are scaled more broadly.

In particular, Ohio is in a unique position to prove how health care innovation can work in a complex market – both from a payer and a provider perspective.

How is Ohio Unique?

- Diverse and fragmented health plan landscape – no single plan with > 20 percent market share statewide
- Medicaid program with a mix of managed care and FFS
- Large, integrated health systems, many of which are beginning to build capabilities to support payment innovation
- Multiple academic medical centers train and export doctors to other states – provides opportunity to export both clinical excellence and team-based care
- Office of Health Transformation with payment innovation as a clear objective within the state’s strategic plan
Case for change in Ohio – why paying for value is needed
- Ohio spends more per person on healthcare than all but 17 states
- But, Ohio has a less healthy workforce than 36 other states
- Transforming health care – ensuring access to quality care for employees and managing costs– is a high priority for Ohio’s employers
- Critical for maintaining a healthy workforce and the health and competitiveness of Ohio’s economy
- The companies shown on this slide are participating in the Governor’s Advisory Council on Health Care Payment Innovation
- Innovation framework and the Office of Health Transformation organizing model reflect Ohio’s approach to address multiple, complicated problems together.
- Pay-for-value, starting in 2013, was always a part of the approach. When the State Innovation Model (SIM) opportunity emerged, it fit perfectly with the state’s original goal to improve health outcomes and care provided while realizing cost savings.

<table>
<thead>
<tr>
<th>Modernize Medicaid</th>
<th>Streamline Health and Human Services</th>
<th>Pay for Value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initiate in 2011</strong></td>
<td><strong>Initiate in 2012</strong></td>
<td><strong>Initiate in 2013</strong></td>
</tr>
<tr>
<td>Advance the Governor Kasich’s Medicaid modernization and cost containment priorities</td>
<td>Share services to increase efficiency, right-size state and local service capacity, and streamline governance</td>
<td>Engage private sector partners to set clear expectations for better health, better care and cost savings through improvement</td>
</tr>
<tr>
<td>• Extend Medicaid coverage to more low-income Ohioans</td>
<td>• Create the Office of Health Transformation (2011)</td>
<td>• Participate in Catalyst for Payment Reform</td>
</tr>
<tr>
<td>• Eliminate fraud and abuse</td>
<td>• Implement a new Medicaid claims payment system (2011)</td>
<td>• Support regional payment reform initiatives</td>
</tr>
<tr>
<td>• Prioritize home and community services</td>
<td>• Create a unified Medicaid budget and accounting system (2013)</td>
<td>• Pay for value instead of volume</td>
</tr>
<tr>
<td>• Reform nursing facility payment</td>
<td>• Create a cabinet-level Medicaid Department (July 2013)</td>
<td>(State Innovation Model Grant)</td>
</tr>
<tr>
<td>• Enhance community DD services</td>
<td>• Consolidate mental health and addiction services (July 2013)</td>
<td>- Provide access to medical homes for most Ohioans</td>
</tr>
<tr>
<td>• Integrate Medicare and Medicaid benefits</td>
<td>• Simplify and replace Ohio’s 34-year-old eligibility system</td>
<td>- Use episode-based payments for acute events</td>
</tr>
<tr>
<td>• Rebuild community behavioral health system capacity</td>
<td>• Coordinate programs for children</td>
<td>- Coordinate health information infrastructure</td>
</tr>
<tr>
<td>• Create health homes for people with mental illness</td>
<td>• Share services across local jurisdictions</td>
<td>- Coordinate health sector workforce programs</td>
</tr>
<tr>
<td>• Restructure behavioral health system financing</td>
<td>• Recommend a permanent HHS governance structure</td>
<td>- Report and measure system performance</td>
</tr>
<tr>
<td>• Improve Medicaid managed care plan performance</td>
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SIM requires each state’s efforts to be governor-led. Governor Kasich has strongly endorsed this initiative and has convened the Ohio Health Care Payment Innovation Task Force and the Governor’s Advisory Council on Health Care Payment Innovation to drive these efforts.

These groups bring together leaders across healthcare stakeholders in Ohio.
Ohio State Health Innovation Plan lays out a 2-part approach, shifting from FFS to both episode-based and population-based payment models. With this approach, episodes-based payments are nested within population-based models. Population models (PCMH, ACOs) focus on prevention and care management (i.e., for chronically ill) to improve quality and manage total cost of care. Episode models focus on incenting best practice care for specific, defined conditions, when those conditions do occur.
Overall, the 5-year focus at the state level is on PCMH and episodes.

For immediate term, the focus is on CPCI for PCMH and development of 5 episode models (with the goal to launch reports in November 2014).
In the Ohio model, episodes are nested within a PCMH structure.

- For both models to succeed, it is critical to coordinate care, ensuring solid handoffs and no fumbles.
- Both episodes and PCMH are core building blocks to move towards payment for value.
- These do not preclude a shift to more aggressive risk models (e.g., ACOs, capitation) but provide the essentials to perform well within these models.
Commercial and managed Medicaid plans are participating. These plans cover nearly 90 percent of Ohio’s population – that’s about 10 million covered lives.
The SIM initiative aspires to drive broad transformation in Ohio, leveraging scale at multiple levels.

Scale is important to creating a sustainable model that can be applied broadly.

The key to health transformation at scale is to take the journey together, to effectively transition in payment and clinical care delivery innovations.

The importance of scale underscores why it’s important to have all these plans participating in SIM.
Agree on degrees of standardization within each model

<table>
<thead>
<tr>
<th>“Standardize approach”</th>
<th>“Align in principle”</th>
<th>“Differ by design”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standardize approach (i.e., identical design) only when:</td>
<td>Align in principle but allow for payer innovation consistent with those principles when:</td>
<td>Differ by design when:</td>
</tr>
<tr>
<td>• Alignment is critical to provider success or significantly eases implementation for providers (e.g., lower administrative burden)</td>
<td>• There are benefits for the integrity of the program for payers to align</td>
<td>• Required by laws or regulations</td>
</tr>
<tr>
<td>• Meaningful economies of scale exist</td>
<td>• It benefits providers to understand where payers are moving in same direction; it’s beneficial to know payers are not moving in different direction</td>
<td>• An area of the model is substantially tied to competitive advantage</td>
</tr>
<tr>
<td>• Standardization does not diminish potential sources of competitive advantage among payers</td>
<td>• Differences have modest impact on provider from an administrative standpoint</td>
<td>• There exists meaningful opportunity for innovation or experimentation</td>
</tr>
<tr>
<td>• It is lawful to do so</td>
<td>• Differences are necessary to account for legitimate differences among payers (e.g., varied customers, members, strategy, administrative systems)</td>
<td></td>
</tr>
<tr>
<td>• In best interest of patients (i.e., clear evidence base)</td>
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With a multi-payer initiative to reach state-wide scale, different elements of the models – both PCMH and episodes – benefit from consistency in design in some areas (i.e., to simplify approach for providers) but require payer-specific differences in others.

In the design process, episode and PCMH working teams (with provider, payer, and state representatives) developed charters outlining the elements of each model on which approach would be standardized, aligned in principle, or different by design.

The main goal was to standardize approach where it will be most helpful to providers (i.e., minimizing differences in report formats).

This approach has allowed us to get as far as we have, as fast as we have.
Ohio’s payment reform activities to date

- Governor’s Advisory Council for payment reform convenes 1.2013
- OHT convenes SIM Core team comprised of state’s five largest payers 6.2013
- Payer and provider PCMH and episode working teams launch 6.2013
- Charters presented to Governor’s Advisory Council 10.2013
- OHT convenes episode Clinical Advisory Groups 11.2013
- SIM Core team expanded to include Medicaid plans 2.2013
- OHT convenes episode and PCMH implementation teams 5.2013

2012
Ohio applies for State Innovation Model (SIM) design grant 9.2012

2013
Ohio receives SIM award 2.2013
SIM funding begins 4.2013
Working teams create multi-payer charters for PCMH and episodes 9.2013

2014
OHT submits State Healthcare Innovation Plan 11.2013
OHT posts episode definitions for Ohio 2.2014
SIM Round 2 funding announced 5.2014
SIM Round 2 funding application due 7.2014
First episode reports to be shared with providers 11.2014
1. Ohio Approach to Paying for Value Instead of Volume
2. Patient-Centered Medical Home Model
3. Episode-Based Payment Model
This group was convened as part of the SIM process to inform the development of the episode strategy for the State Health Innovation Plan.
This lays out all the elements needed for a comprehensive PCMH strategy. While we won’t go into all the details right now, we want to highlight that this is a sophisticated model and we are embracing the complexity needed to do it right.
Ohio already has various PCMH projects underway

<table>
<thead>
<tr>
<th>Major focus of pilots</th>
<th>Some focus</th>
<th>Minimal or no focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>HB 198 Education Pilot Sites</td>
<td>- 42 pilot sites target underserved areas</td>
<td>- Potential to add 50 pediatric pilots</td>
</tr>
<tr>
<td>NCQA, AAAHC, Joint Commission</td>
<td>- 405 NCQA-recognized sites</td>
<td>- 50 Joint Commission accredited sites</td>
</tr>
<tr>
<td></td>
<td>- 7 AAAHC-accredited</td>
<td></td>
</tr>
<tr>
<td>Cincinnati/Dayton CPCi</td>
<td>- 61 sites in OH (14 in KY), incl. Tri-Health, Christ Hospital, PriMed, Providence, St. Elizabeth (KY)</td>
<td></td>
</tr>
<tr>
<td>Private Payer Pilots</td>
<td></td>
<td>- Vary in scope by pilot, but tend to focus on larger independent or system-led practices</td>
</tr>
</tbody>
</table>

| Care delivery model | | | |
| Payment model | | | |
| Infrastructure | | | |
| Scale-up and practice performance improvement | | | |

Source: Ohio Patient-Centered Primary Care Collaborative, ODH; as of May 2013.
CPC includes many of the elements we are looking for in a broad PCMH initiative.

Focus for initial year of SIM has been to let this model take shape in Southwest Ohio, and learn from this experience as we develop an approach for broader rollout.
1. Ohio Approach to Paying for Value Instead of Volume
2. Patient-Centered Medical Home Model
3. Episode-Based Payment Model
This group was convened as part of the SIM process to inform the development of the episode strategy for the State Health Innovation Plan.
The episode-based payment strategy requires takes into account the complexity surrounding each type of care.
Ohio episode model is RETROSPECTIVE, not prospective.

To repeat, there is not pre-set price for a bundle in the retrospective model.

Patients seek care and providers bill and are reimbursed as they do today. After the fact, claims data is analyzed to:
- identify the principal accountable provider, or PAP, who is held accountable for all episode costs, not just those he/she directly bills for
- calculate the average episode code per PAP and compare to set “commendable” and “acceptable” thresholds to determine any gain or risk sharing
Let’s walk through this chart to understand how the performance assessment works in the retrospective episode model.
There is 1 bar for each principal accountable provider. The height of the bar represents that PAP’s average episode cost across all their episodes in a given time frame, after adjustments have been applied (i.e., risk adjustment, outlier and other exclusions).
The bars are ordered from left to right, from the PAP with the highest average episode cost to the PAP with the lowest average episode cost.

If a PAP’s average cost is above a pre-set “acceptable” threshold (those in red, on the left), they may be at risk and pay back some of the cost to the payer.
If a PAP’s average cost is below a pre-set “commendable” threshold (those in green, on the right), they may share in the savings.

However, if these low-cost PAPs have an average episode cost below a gain-sharing limit, their savings will be capped, to reduce the incentive to limit care.
In addition, PAPs must also achieve certain clinical quality metrics (defined for each episode) to receive gain-sharing. The blue bars indicate PAPs who met the cost requirements for gain sharing but did not meet the quality requirements.

This model rewards both absolute performance – with shared savings for those who are already performing commendably - and performance improvement, with potential for gain-sharing (or to move out of risk-sharing) as PAPs improve.
The thresholds are not meant to be constantly moving targets, but to give everyone a chance to improve performance and realize gain-sharing.
These are the core elements of the episode definition. This structure is used to develop the definition of each episode. The episode definitions were developed with input from well over 100 providers participating in Clinical Advisory Groups, and informed by rigorous claims data analytics (available on the OHT website).

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Episode trigger</td>
<td>Diagnoses or procedures and corresponding claim types and/or care settings that characterize a potential episode</td>
</tr>
<tr>
<td>Episode window</td>
<td>- <strong>Pre-trigger window</strong>: Time period prior to the trigger event; relevant care for the patient is included in the episode</td>
</tr>
<tr>
<td></td>
<td>- <strong>Trigger window</strong>: Duration of the potential trigger event (e.g., from date of inpatient admission to date of discharge); all care is included</td>
</tr>
<tr>
<td></td>
<td>- <strong>Post-trigger window</strong>: Time period following trigger event; relevant care and complications are included in the episode</td>
</tr>
<tr>
<td>Claims included</td>
<td></td>
</tr>
<tr>
<td>Principal accountable provider</td>
<td>Provider who may be in the best position to assume principal accountability in the episode based on factors such as decision making responsibilities, influence over other providers, and portion of the episode spend</td>
</tr>
<tr>
<td>Quality metrics</td>
<td>Measures to evaluate quality of care delivered during a specific episode</td>
</tr>
<tr>
<td>Potential risk factors</td>
<td>Patient characteristics, comorbidities, diagnoses or procedures that may potentially indicate an increased level of risk for a given patient in a specific episode</td>
</tr>
<tr>
<td>Episode-level exclusions</td>
<td>Patient characteristics, comorbidities, diagnoses or procedures that may potentially indicate a type of risk that, due to its complexity, cost, or other factors, should be excluded entirely rather than adjusted</td>
</tr>
</tbody>
</table>
The patient journey is used to illustrate and define an episode of care. In this example, the surgery itself is the “trigger” event to identify that a potential episode has occurred. Then, the types of care that a patient is likely to receive both before and after that trigger event are assessed to identify the types of claims that would be defined as part of the episode.
The patient journey is used to illustrate and define an episode of care. In this example, the surgery itself is the “trigger” event to identify that a potential episode has occurred. Then, the types of care that a patient is likely to receive both before and after that trigger event are assessed to identify the types of claims that would be defined as part of the episode.
- Each bar represents the average spend for a PAP’s valid episodes (after clinical and business exclusions), arranged from highest cost on the left to lowest cost on the right.
- Episode spend includes all the relevant claims in the episode window, as detailed in the episode definition, including pharmacy, OP, IP, professional, or long term care / rehab.
- Episode spend costs included in these calculations will be risk-adjusted, to ensure providers are not unfairly disadvantaged for seeing more complex, high-cost patients.
The State has developed detailed episode definitions and business requirements for the episodes on the right. Medicaid will be implementing all of these episodes. Commercial plans have been asked to select at least three.
- Many types of conditions could be potentially be addressed through episode-based models, and a large amount value could be at stake
- Ohio’s current set of episodes focuses on acute medical (COPD, asthma) and procedural (Hip/knee, PCI, perinatal) events
Payers are currently in the process of customizing the episode details as appropriate (i.e., setting outliers, payer-specific exclusions).

While commercial payers are each doing this separately, the managed Medicaid plans will take a consistent approach to customization, with the exception of anything related to setting thresholds or payments (which will remain payer-specific).
- Episode reports will be a valuable tool for providers to assess their practice patterns and identify opportunities for improvement
- These reports will provide data to understand their performance, including comparisons to other PAPs on overall costs, cost categories, and quality metrics, and details to understand episodes more thoroughly
- Reports will be shared by payers directly with each eligible PAP (identifying by billing provider)
- While reports for each episode will be provided separately by each participating payer, the goal is to align the look and feel of the reports, to make interpretation easier for providers
The goal of this approach is to enable a shift to value-based models to maximize quality and effectively manage costs, while minimizing disruptions to day-to-day processes.
What this all means for patients

• No direct changes to how individuals seek care or select providers

• Goal that new information (e.g., reports) and incentives to providers will lead patients to experience:
  — More coordinated care across all providers
  — A more person-centered approach to healthcare
  — Increasingly receive more emphasis on health, wellness, and health system accountability once a health issue arises
What this all means for providers

- Continue to deliver care to patients and submit fee-for-service claims (unless they have contracted an alternative model with individual payers)
- Experience a more consistent payment methodology, reinforcing the shift to value-based care
- Ability to reach scale within a practice based on multi-payer participation
- Receive reports/data to better understand performance and identify opportunities to improve
- May receive additional financial incentives based on delivery of high quality, efficient care
- May receive funds to support care coordination activities or practice transformation (PCMH)
What this all means for purchasers

• Continue to work with payers to gain health care coverage for employees and families

• Where they manage their own risk pools, will share benefits with providers, who are increasingly incented and able to provide more value-based care

• Will over time see additional benefit in healthier workforce

• Play role in enabling value-based models to be adopted at scale, increasing ability to effectively manage healthcare costs and improve quality
What this all means for payers

- Continue to contract with providers and purchasers on an individual basis, and create and deliver products for customers
- Run additional analytics to evaluate, incent, and support providers’ value-based care
- Share reports with providers to enhance understanding of their own performance and inform opportunities for change
- Where they manage risk pools directly, will share benefits with providers
Ohio is ready to test its model

Ohio applying for SIM Round 2 funding for model testing

- Up to $700M to be allocated to up to 12 states
- Test innovative payment and service delivery models over a 4-year period

Timeline

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
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<tbody>
<tr>
<td>5/22/14</td>
<td>Federal announcement</td>
</tr>
<tr>
<td>6/6/14</td>
<td>Ohio letter of intent to apply</td>
</tr>
<tr>
<td>7/21/14</td>
<td>Round 2 application due</td>
</tr>
<tr>
<td>10/31/14</td>
<td>Anticipated notice of award</td>
</tr>
<tr>
<td>1/1/15-12/31/18</td>
<td>Performance period</td>
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</tbody>
</table>
We would encourage you to visit the OHT website for additional resources.

Several presentations and documents from SIM overviews to detailed analytics that informed the episode design process are available.