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Health Transformation in Ohio

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Governor's Office of Health Transformation

BWC Health Care Workshop
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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

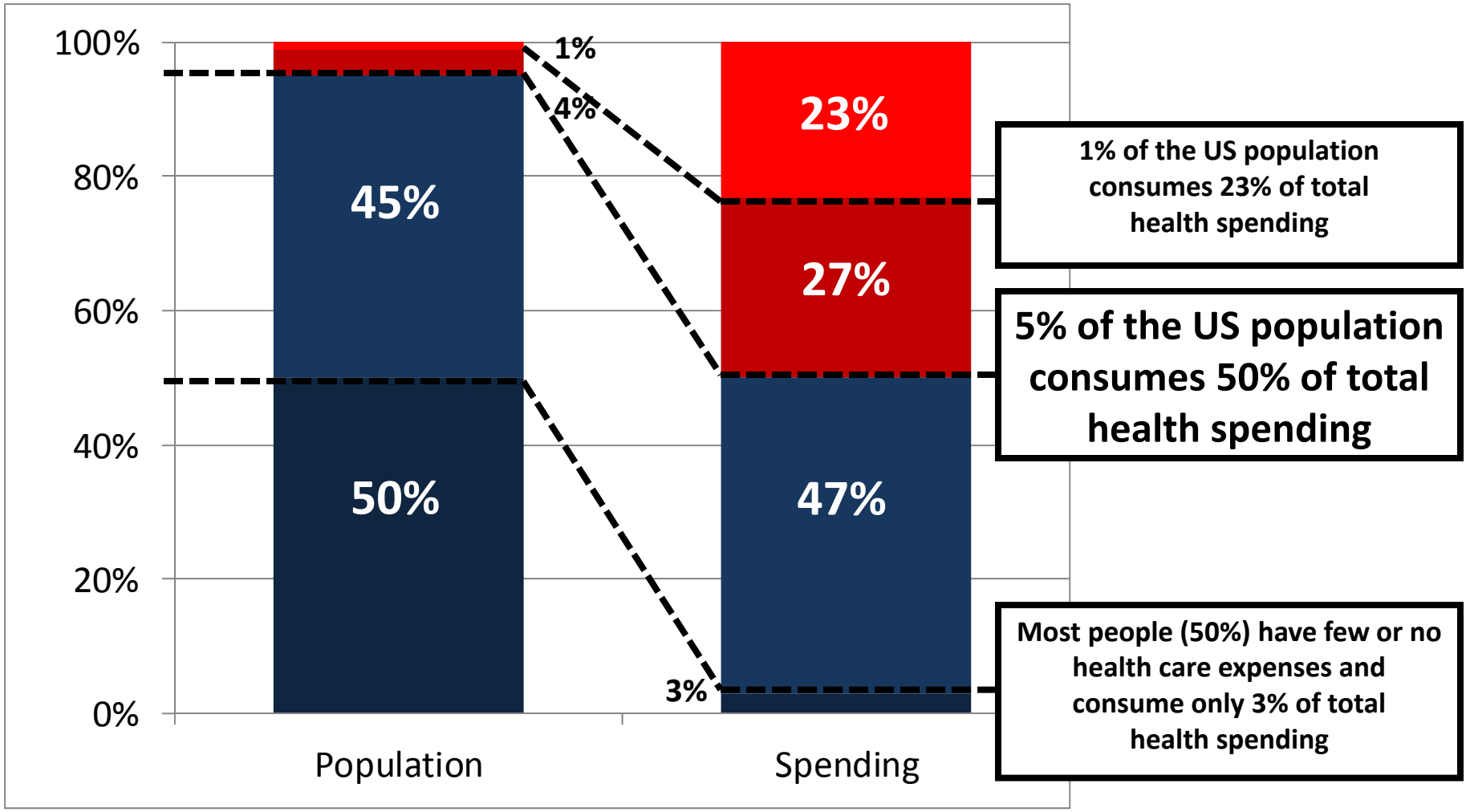
It is important to understand the overall challenges and trends to identify opportunities

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

Agenda

1. **Health System Challenges**
2. Pay for Value
3. Coordinate Care

A few high-cost cases account for most health spending



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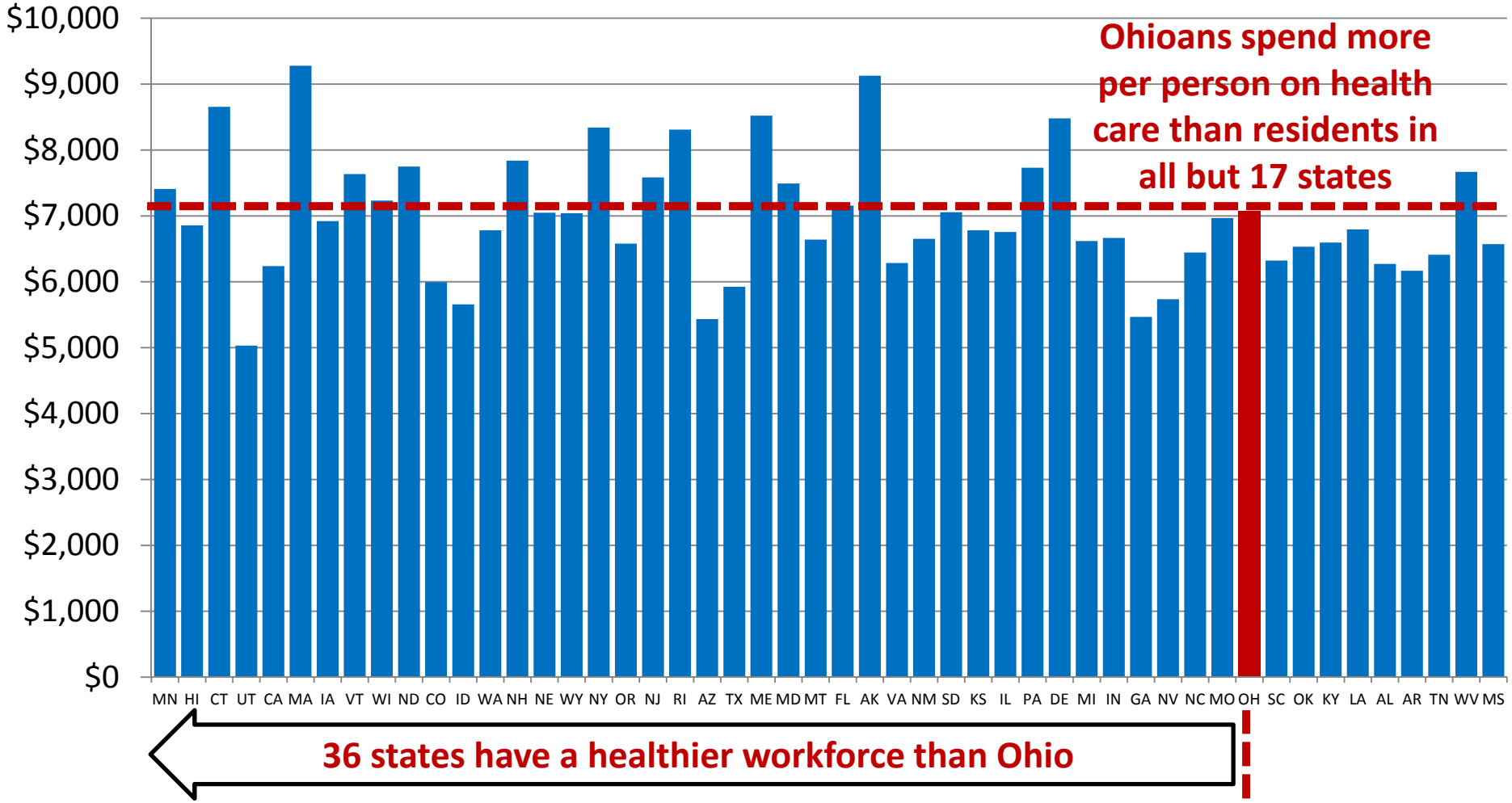
Source: Kaiser Family Foundation calculations using data from AHRQ Medical Expenditure Panel Survey (MEPS), 2007

Health Care System Choices

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• Multiple separate providers • Provider-centered care • Reimbursement rewards volume • Lack of comparison data • Outdated information technology • No accountability • Institutional bias • Separate government systems • Complicated categorical eligibility • Rapid cost growth		•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

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

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).

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

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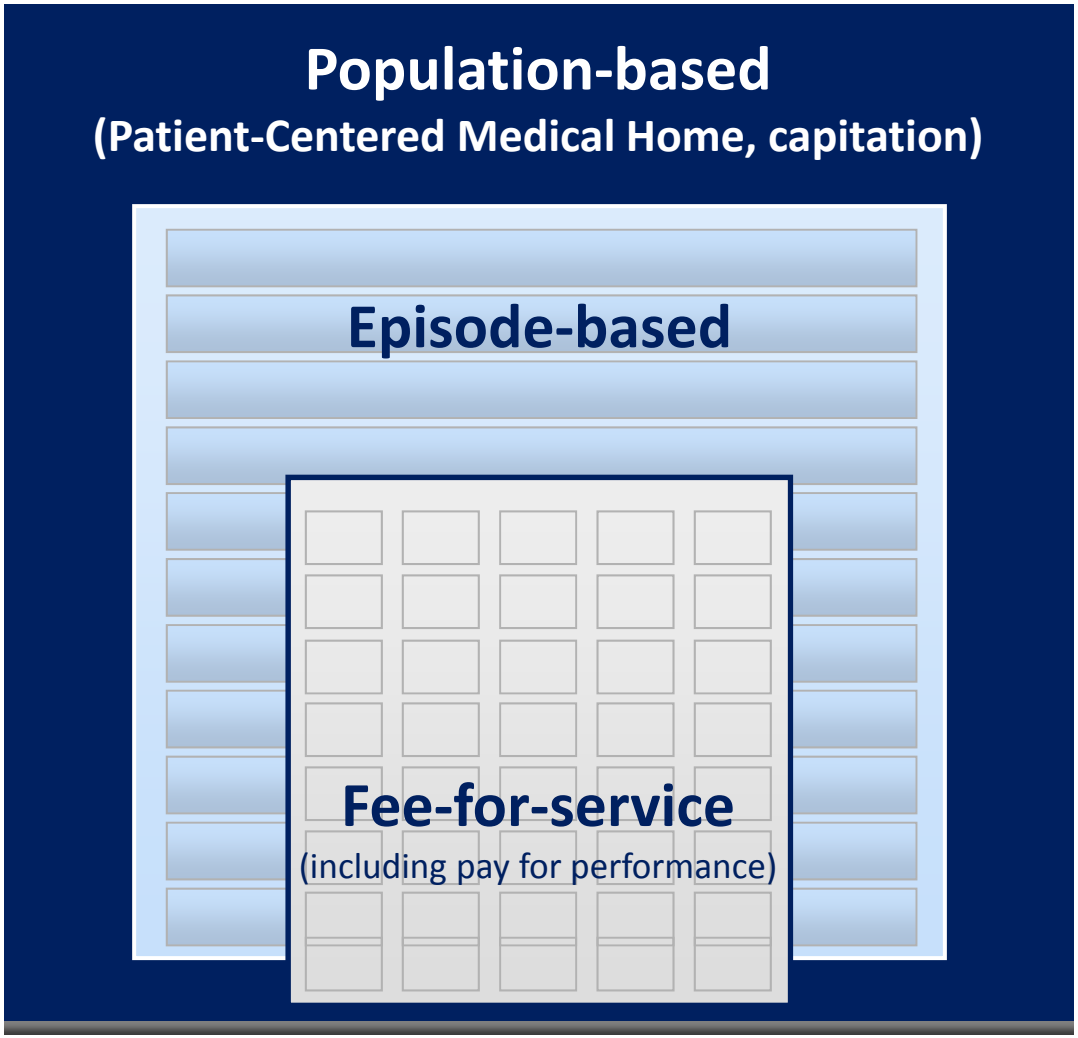
Shift from fee-for-service to value-based payment

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	
Year 5	▪ Scale achieved state-wide ▪ 80% of patients are enrolled	

1. **Perinatal**
2. **Asthma acute exacerbation**
3. **COPD exacerbation**
4. **Joint replacement**
5. **Percutaneous coronary intervention (PCI)**

Ohio's Payment Innovation Partners:

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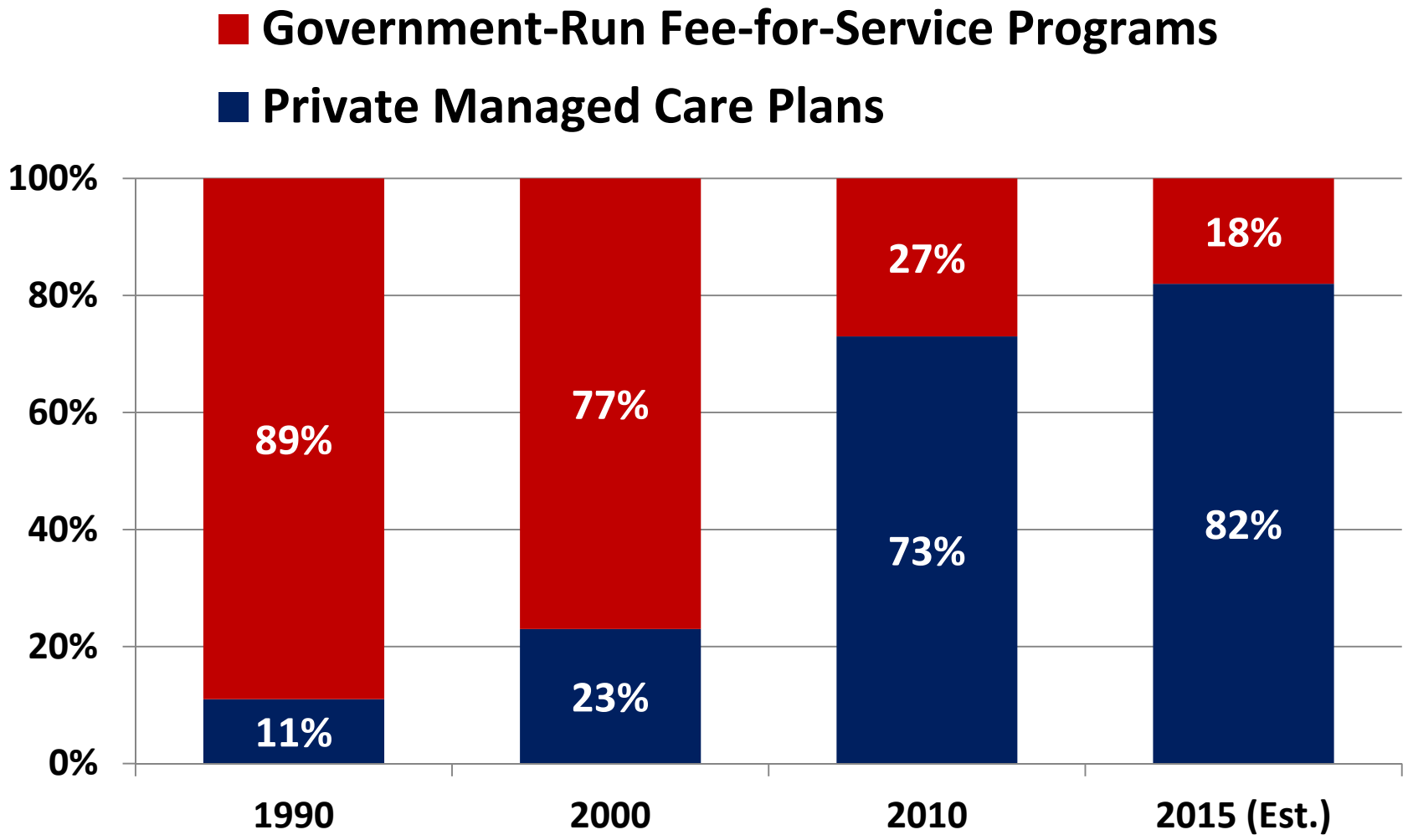
Ohio Medicaid Increasingly Relies on Managed Care



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

Improve Managed Care Plan Performance

Competitively rebid managed care contracts in 2012

- Went from 7 plans in 8 regions to 5 plans statewide; increased choice for enrollees from 2 or 3 plans per region to 5
- Increased administrative efficiency; cut administrative rates 1% in 2011 and another 1% in 2013
- Redesigned the overall care management model to place greater emphasis on helping the most high need individuals
- Created a pharmacy lock-in option for plans to limit high-risk members to one physician and one pharmacy
- Use low-acuity non-emergent (LANE) methodology to identify preventable emergency room use
- Required managed care plans to locate key personnel and member services call centers in Ohio

Improve Managed Care Plan Performance

Getting Results

- Saving Ohio taxpayers' money:
  - 2011 reforms saved $144 million ($52 million state) 2012-2013
  - 2013 reforms will save $646 million ($239 million state) 2014-2015
- Reforms allowed the following adjustments to 2013 rates:
  - 8% decrease to emergency room
  - 1.5% decrease to inpatient hospital
  - 12% decrease to pharmacy
- Better high-risk care management is cutting costs:
  - One plan achieved a 51% reduction in inpatient hospital costs and a 5% reduction in medical costs, including outpatient and ED visits, in 2012
  - Another plan reported a 20% reduction in inpatient hospital and ED visits for 1,300 members enrolled in high-risk care management

Comparing Ohio's Care Management Systems

	Ohio Medicaid	Ohio Bureau of Workers' Compensation
Number of plans	5	17
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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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

Consolidate mental health and addiction services
Create a cabinet-level Medicaid department
Modernize eligibility determination systems
Coordinate health sector workforce programs
Coordinate programs for children
Share services across local jurisdictions

Improve Overall Health System Performance

Pay for health care based on value instead of volume
Encourage Patient-Centered Medical Homes
Accelerate electronic Health Information Exchange
Federal Health Insurance Exchange

Appendices

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Health Transformation 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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5-Year Goal for Payment Innovation

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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

Elements of a Patient-Centered Medical Home Strategy

Care delivery model	Target patients and scope Care delivery improvements e.g., ▪ Improved access ▪ Patient engagement ▪ Population management ▪ Team-based care, care coordination 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 Attribution / assignment Quality measures Payment streams/ incentives 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 Payer infrastructure Payer / PCMH infrastructure PCMH/ Provider infrastructure 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 Practice transformation support Workforce / human capital Legal / regulatory environment Network / contracting to increase participation ASO contracting/participation Performance transparency Ongoing PCMH support Evidence, pathways, & research 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

Participation	Provider participation Payer participation } Related to 'scale-up' plan for episodes
Account-ability	Providers at risk – Number Providers at risk – Type of provider(s) Providers at risk – Unique providers Cost normalization approach
Payment model mechanics	Prospective or retrospective model Risk-sharing agreement – types of incentives Approach to small case volume Role of quality metrics Provider stop-loss Absolute vs. relative performance rewards
Performance management	Absolute performance rewards – Gain sharing limit Approach to risk adjustment Exclusions
Payment model timing	Preparatory/"reporting-only" period Length of "performance" period Synchronization of performance periods
Payment model thresholds	Approach to thresholds How thresholds change over time Specific threshold levels Degree of gain / risk sharing Cost outliers

Episode-specific design decisions

Core Episode definition	Quarterback selection Triggers Episode timeframe – Type/length of pre-procedure/ event window Claims in- or excluded: pre-procedure/event window Claims in- or excluded: during procedure/event Claims in- or excluded: post procedure/event (incl. readmission policy)
Episode cost adjustment	Risk adjustors Unit cost normalization - Inpatient Unit cost normalization - Other Adjustments for provider access Approach to cost-based providers Clinical exclusions
Quality metric selection	Approach to non-claims-based quality metrics Quality metric sampling Quality metrics linked to payment 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

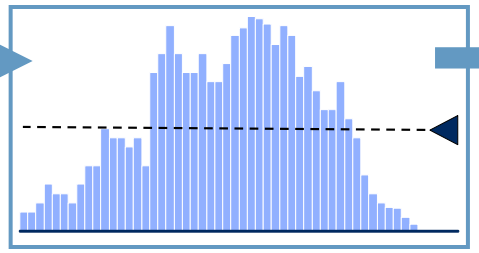
Payers reimburse for all services as they do today

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]



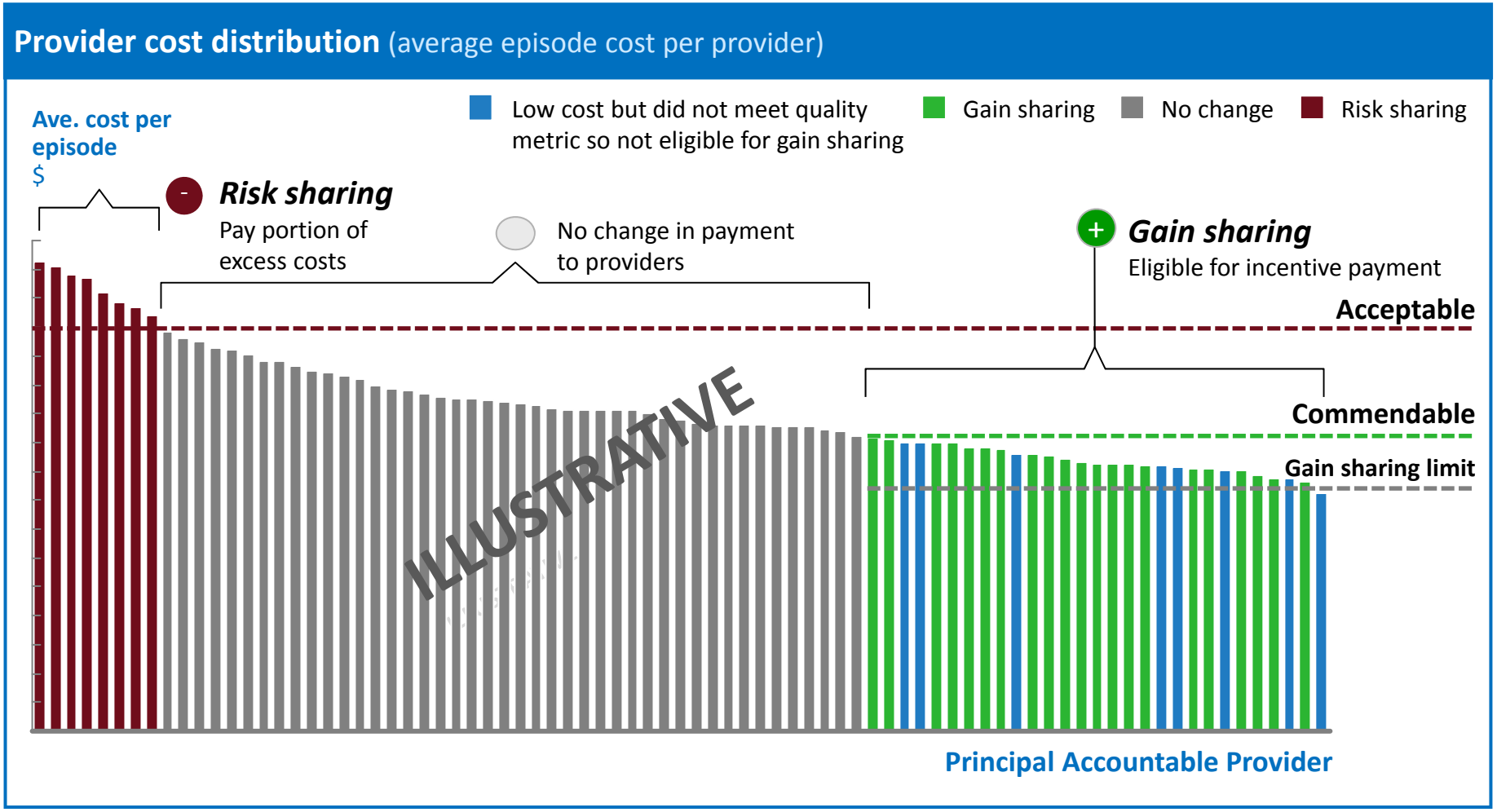
Compare average costs to predetermined ''commendable' and 'acceptable' levels[2]

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



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NOTE: Each vertical bar represents the average cost for a provider, sorted from highest to lowest average cost

What this all means for Ohio's stakeholders

Patients	▪ Experience a more person-centered approach to healthcare, receiving support to coordinate care across all providers ▪ Increasingly receive more emphasis on health, wellness, and health system accountability once a health issue arises
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 shift to value-based care ▪ May receive additional incentives based on delivery of high quality, efficient care ▪ May receive funds to support care coordination activities or practice transformation
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 incentivized and able to provide more value-based care ▪ Will over time see additional benefit in healthier workforce
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 ▪ Where they manage risk pools directly, will share benefits with providers