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Transforming Payment for a Healthier Ohio

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Healthcare Collaborative of Greater Columbus
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www.HealthTransformation.Ohio.gov

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How can purchasers in Greater Columbus work with others to align new health care delivery payment systems to reward the value of services, not the volume?

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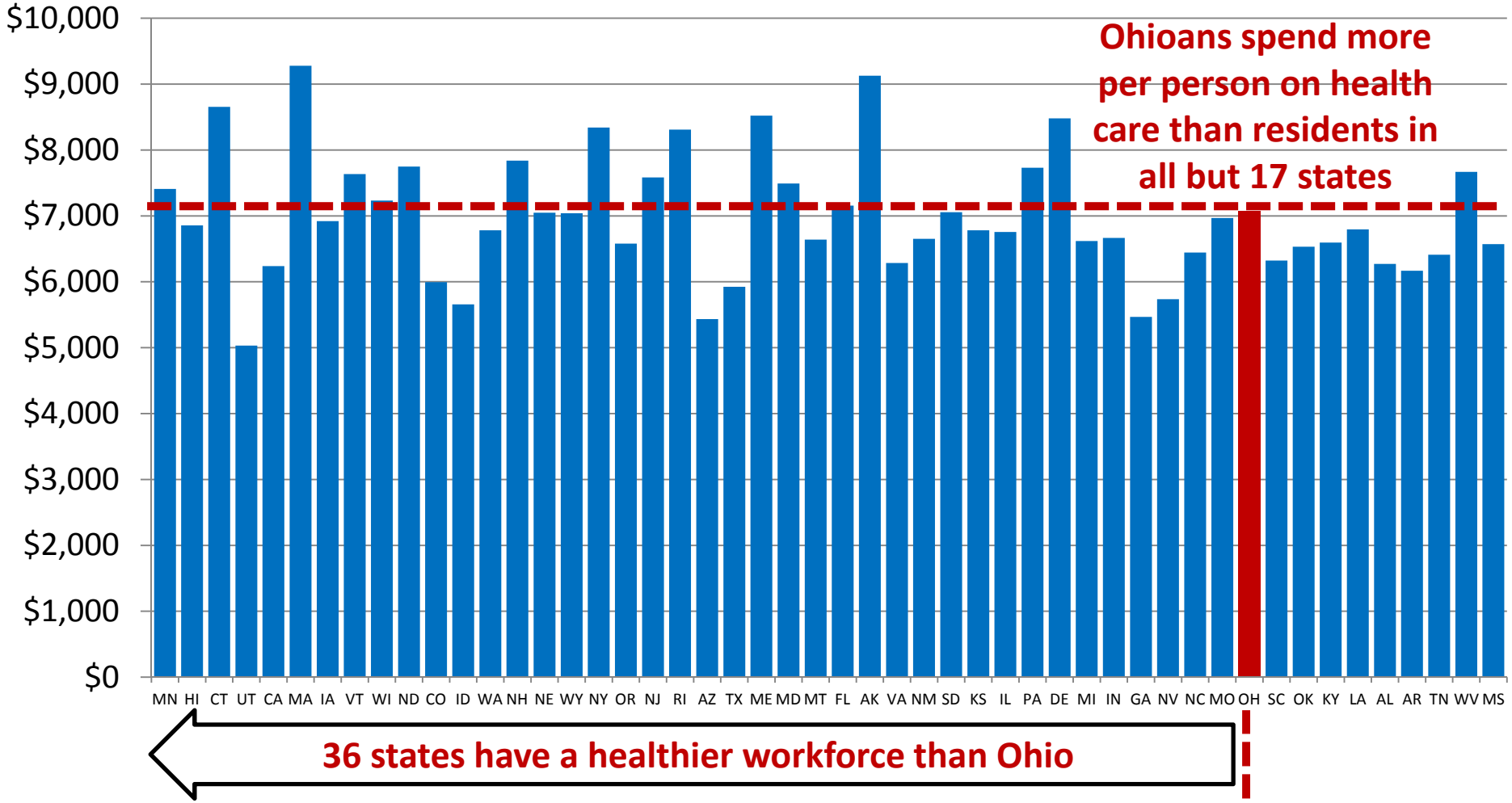
Agenda

1. **Health System Challenges**
2. Pay for Value
3. Patient-Centered Medical Homes
4. Episode-Based Payments

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



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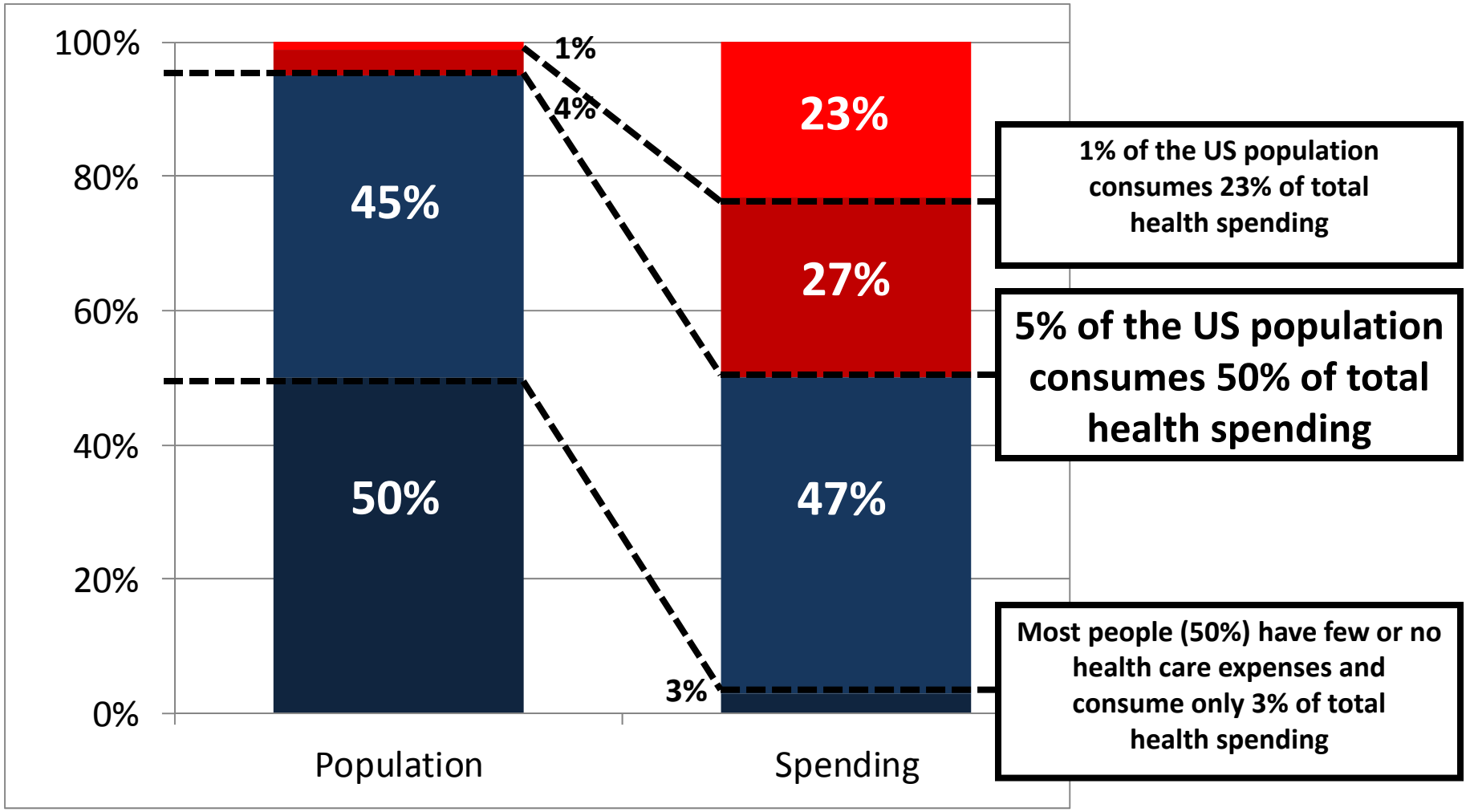
Sources: CMS *Health Expenditures by State of Residence* (2011); The Commonwealth Fund, *Aiming Higher: Results from a State Scorecard on Health System Performance* (October 2009).

A few high-cost cases account for most health spending



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

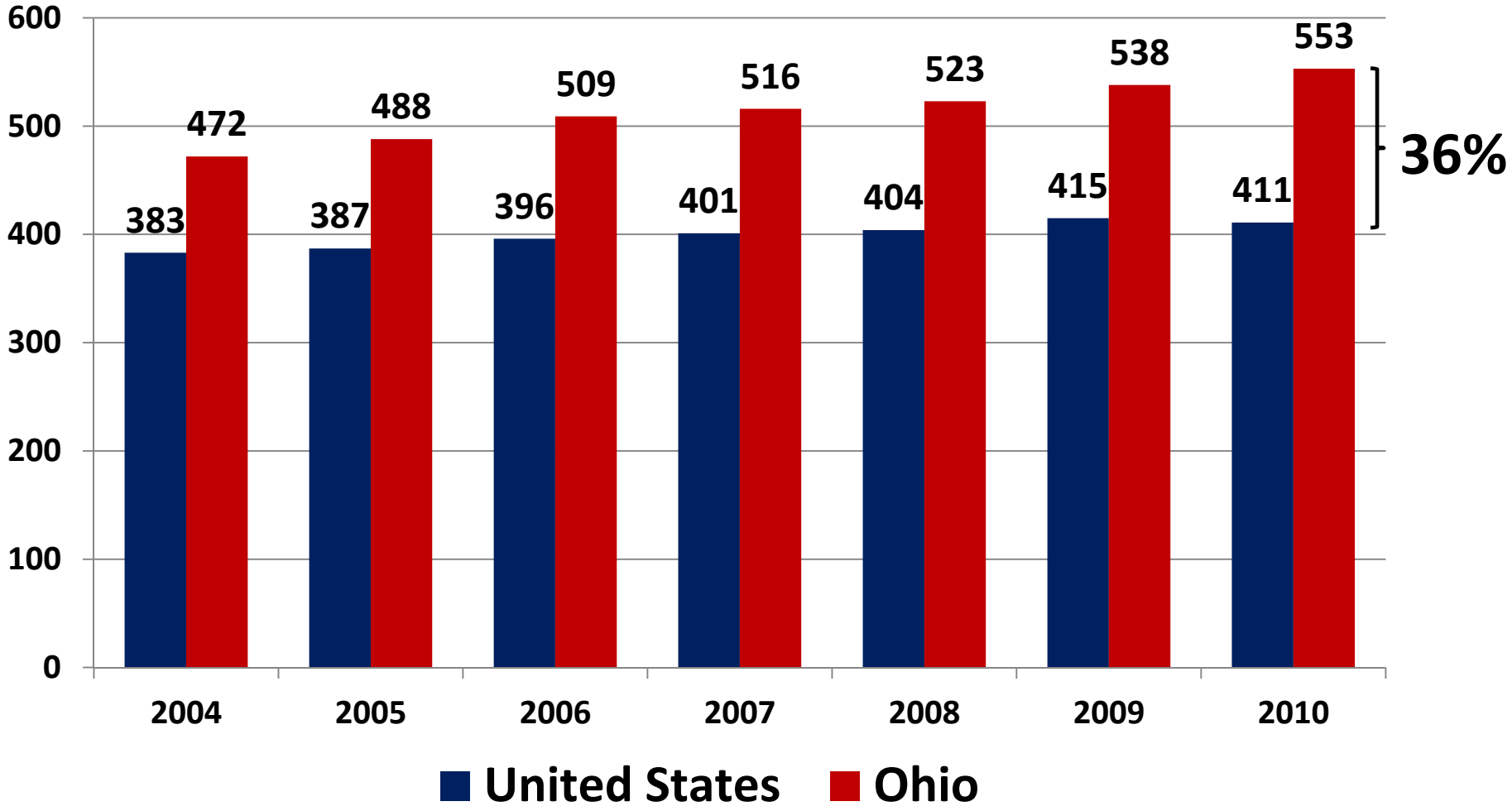
Health Care System Choices

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• Multiple separate providers • Provider-centered care • Reimbursement rewards volume • Lack of comparison data • Outdated information technology • No accountability • Institutional bias • Separate government systems • Complicated categorical eligibility • Rapid cost growth		•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

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.

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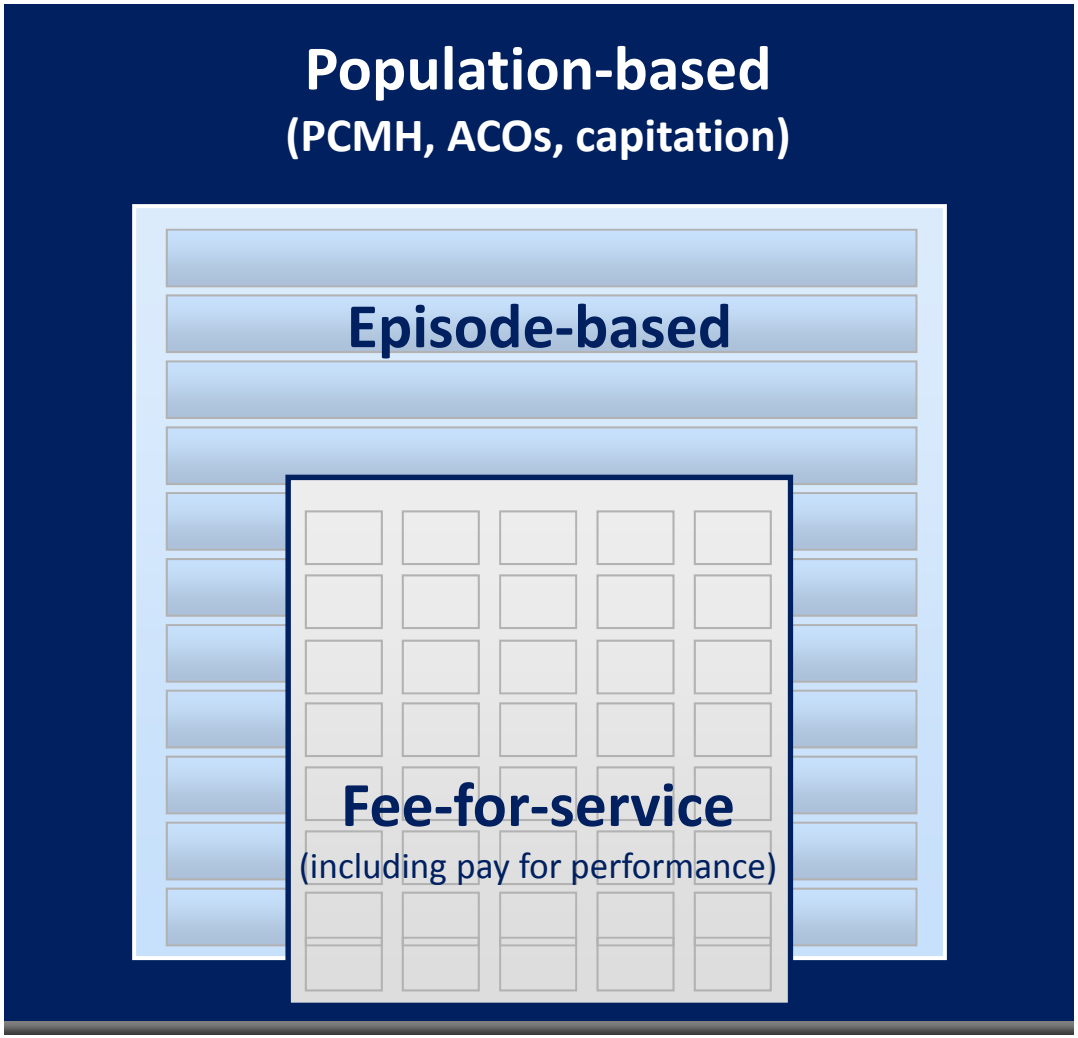
Health Innovation Framework

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

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	
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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Patient-Centered Medical Homes

- Reset the basic rules of health care competition so the incentive is to keep Ohioans as healthy as possible
- Research shows that health care that is primary-care centric is lower cost, higher quality, and produces fewer disparities than specialist-centered care delivery
- The PCMH model makes primary care the center of medical practice and rewards practices that provide better care:
  - Multi-disciplinary team-based approach to care
  - Planned visits and follow up care
  - Population-based tracking and analysis with patient-specific reminders
  - Care coordination across settings, including referrals and transitions
  - Integrated clinical care management focused on high-risk patients
  - Engage the patient in goal setting, action planning, problem solving
  - Evidence-based care delivery and integration of quality improvement
  - Enhanced access, including 24/7 practice coverage

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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PCMH: Demonstrating Value

- The Boeing Company conducted a pilot of a medical home focused on care for its highest-risk employees
  - Costs dropped 20 percent relative to a comparison group
  - Missed work days dropped 57% compared to baseline
  - Physical and mental function improved compared to baseline
- BCBS of North Dakota and medical group MeritCare conducted a pilot focused on care of diabetic patients:
  - Total cost per member per years were $530 lower than expected in the intervention group based on historical trends
  - There was an 18 percent increase in the proportion of diabetics who received a bundle of five recommended services
  - Several other pilots have recently reported similar results

SOURCE: *Establishing Medical Homes*, Catalyst for Payment Reform

PCMH: Actions for Purchasers

- Ask your insurers/TPA what steps have been taken to support and test the medical home concept
- Encourage or require participation in a multi-payer pilot of at least three years in duration if no steps have been taken, and make sure the following are addressed:
  - Adequate practice transformation support – most practices can't do this by themselves
  - Payment that supports infrastructure costs, but also creates incentives to save money and improve quality
  - An ongoing process to study impact and make course corrections – most initiatives won't get it all right the first time
  - Comprehensive evaluation
- Request a seat on the governance body and make sure that employer interests are given attention by your insurer/TPA

SOURCE: *Establishing Medical Homes*, Catalyst for Payment Reform

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Episode-Based Payment

- An episode-based payment is a single price for all of the services needed by a patient for an entire episode of care
  - Includes reimbursement for all of the services needed by a patient, across multiple providers and possibly multiple settings, for a treatment or condition
- The goal is to reduce the incentive to overuse unnecessary services within each episode, and give health care providers the flexibility to decide what services should be delivered
- Requires providers to assume risk for the efficient and effective delivery of a bundle of services
  - If the incurred costs exceed the payment, the participating providers are at financial risk for the difference
  - Or they receive a financial gain if costs are less than the payment

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

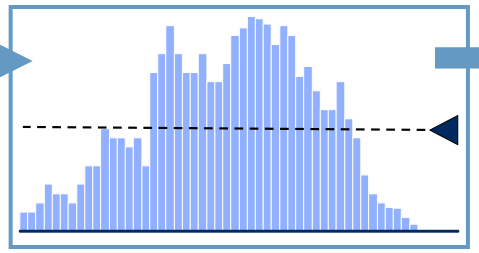
Payers reimburse for all services as they do today

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]



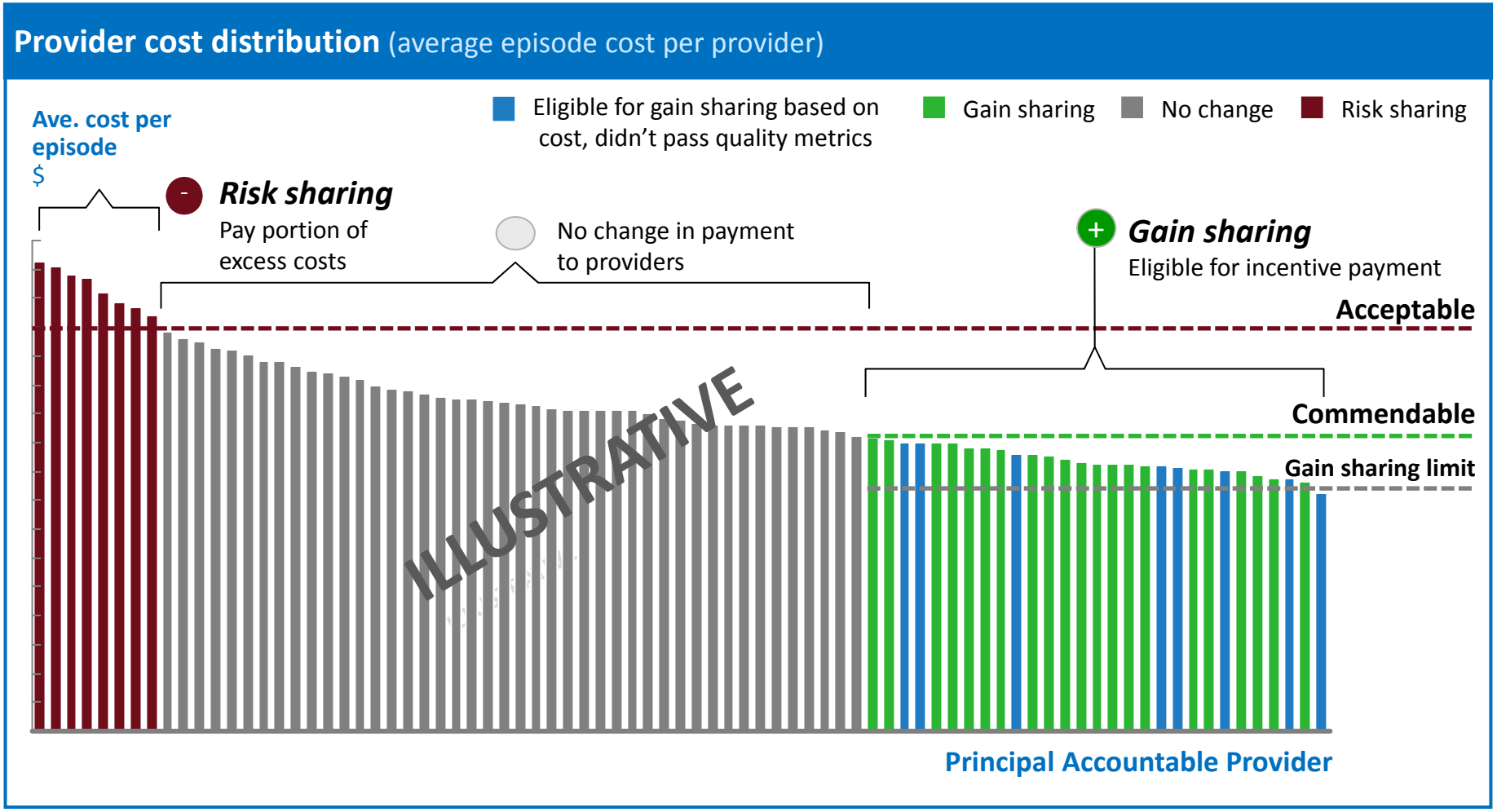
Compare average costs to predetermined ''commendable' and 'acceptable' levels[2]

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

Episode Payment: Actions for Purchasers

- Encourage your insurer/TPA to enter bundled payment arrangements
- Consider modifying the benefit plan to provide incentives for employees to seek care from highly performing providers being reimbursed with bundled payments for specific services or conditions
- Anticipate a multi-year transition, and encourage your insurer/TPA to phase in implementation, allowing providers to assume gradually increasing responsibility for more services within the bundle, and for more financial risk

SOURCE: *Establishing Medical Homes*, Catalyst for Payment Reform

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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