Ohio's health and human services transformation plan

Modernize Medicaid

Initiate 2011

Advance the Governor's Medicaid and cost containment priorities

- Extend Medicaid coverage to more low-income Ohioans
- Eliminate fraud and abuse
- Prioritize home and community based services
- Enhance community developmental disabilities 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

Streamline health and human services

Initiate 2012

Recommend a permanent health and human services organization structure and oversee transition to that structure

- Implement a new Medicaid claims payment system
- Create a unified Medicaid budgeting and accounting system
- Create a Department of Medicaid
- Consolidate mental health and addiction services
- Share services across local jurisdictions (individual projects)
- Simply and integrate eligibility determination
- Recommend a permanent HHS structure

Improve overall health system performance

Initiate 2013

Engage private sector partners to set clear expectations for better health, better care, and lower costs through improvement

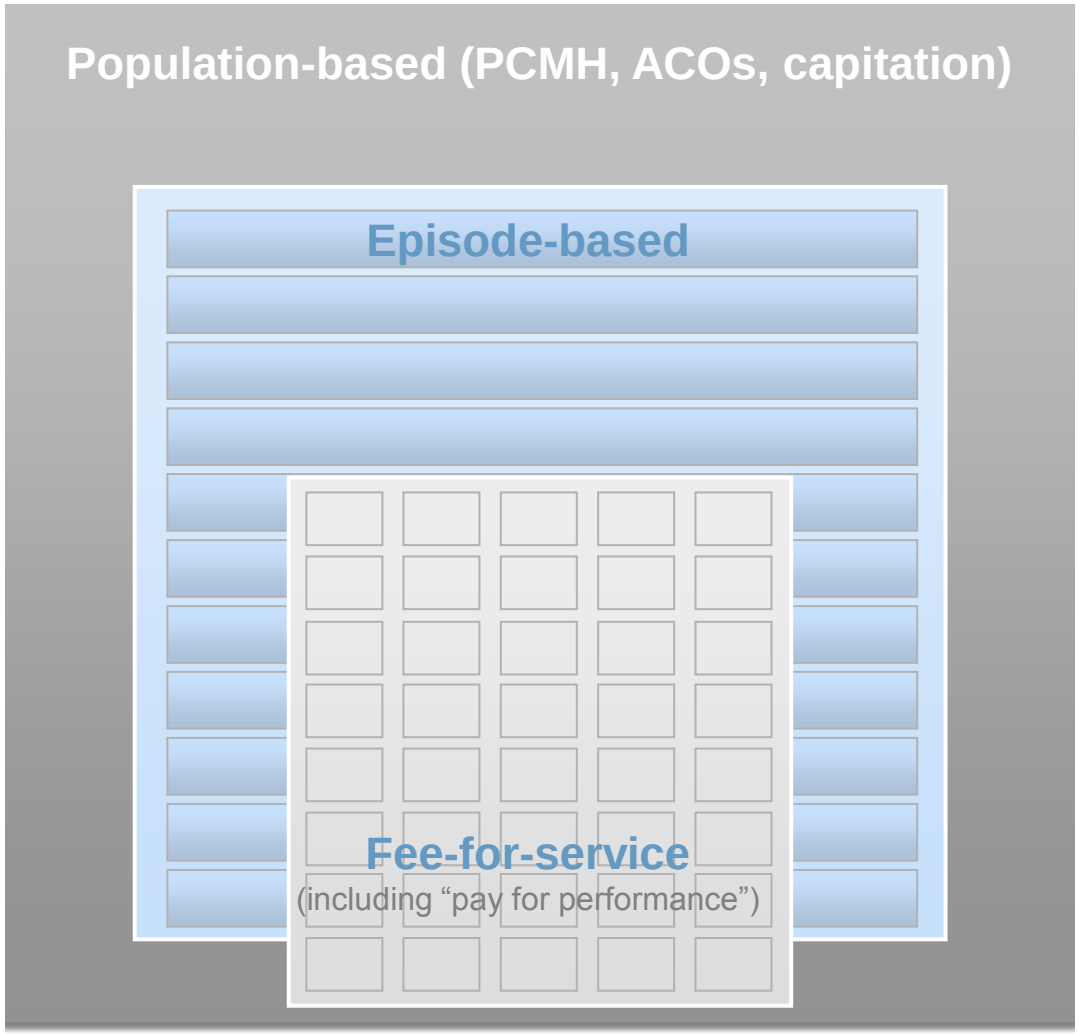
- Participation in Catalyst for Payment Reform
- Support regional payment reform initiatives
- Pay for value instead of volume (State Innovation Model)
  - Provide access to medical homes for most Ohioans
  - Use episode-based payments for acute medical events
  - Coordinate health sector workforce and training programs
  - Coordinate health information technology infrastructure
  - Report and measure health system performance

Working with stakeholders to define Ohio's vision

- Ohio Governor's Office of Health Transformation convened various stakeholder groups to provide detailed input on payment model design
  - Over 50 stakeholders (payers, providers, payment innovation experts) from throughout Ohio participating in weekly PCMH and episode design sessions
  - Bi-weekly leadership meetings with multi-payer group
  - Weekly sessions with representatives from State agencies to define tactical plan for implementation
- Ohio will submit a State Healthcare Innovation Plan to CMS in October
  - Plan will include Ohio's plan for expanding PCMH and episodes to 80 percent of population over 5 years
  - Meeting scheduled with Governor's Advisory Council to review the plan

Shift to population-based and episode-based payment

Payment approach



Most applicable

- Primary prevention for healthy
- 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, URI)

Discrete services correlated with favorable outcomes or lower cost

Why medical homes *and* episodes?

Medical homes provide the foundation for total cost/quality accountability	Episodes "nested" within total cost of care for more specific accountability
▪ **Population-based** accountability transcends delivery system ▪ **Large long-term impact:** prevention and chronic disease management ▪ Requires providers to fully **transform business model** away from FFS ▪ Requires significant provider **capabilities and commitment**	▪ **Patient-centered** design around the "patient journey" thru delivery system ▪ **Faster to impact:** clear and specific opportunities for improvement ▪ **Stages business model transition** away from FFS for specialists/hospitals ▪ **Faster to scale,** independent of market structure or capabilities

Fit with other models	**Both models being implemented agnostic of provider structure, can be "carved out" or "carved in" for ACO or capitation**

Five year plan to launch PCMH and episode model at scale

Goal

80-90% of Ohio's population in some **value-based payment model** (combination of episodes- and population-based payment) within **5 years**

State's role

- Shift rapidly to PCMH and episode model in Medicaid FFS
- Require Medicaid MCO partners to participate / implement
- Incorporate into contracts of MCOs for state employee benefit program

	Patient centered medical homes	Episode-based payments
Year 1	▪ In 2014 **focus on 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 **5** episodes – perinatal, asthma (acute exacerbation), 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

We have outlined degrees of standardization

"Standardize approach"

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

- Alignment is critical to provider success or significantly eases implementation for providers (e.g., due to 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

Elements of a PCMH 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 prioritized 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

PCMH could roll out across Ohio in “waves” of markets

Wave 1

- Pilot multi-payer PCMH care delivery and payment model in SW Ohio CPCi (Cincinnati-Dayton-NW Kentucky)
- Note: Already started in 2013

Wave 2

- Reach scale in Cincinnati-Dayton region
- Roll-out in Columbus or Cleveland
- Roll-out to rural counties of Wave 2 markets where model can reach scale

Wave 3

- Roll-out and achieve scale in all Ohio markets, both urban and rural

Retrospective episode model

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

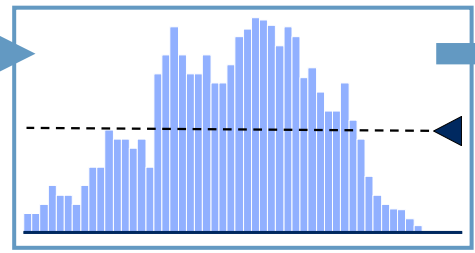
Payers reimburse for all services as they do today

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]



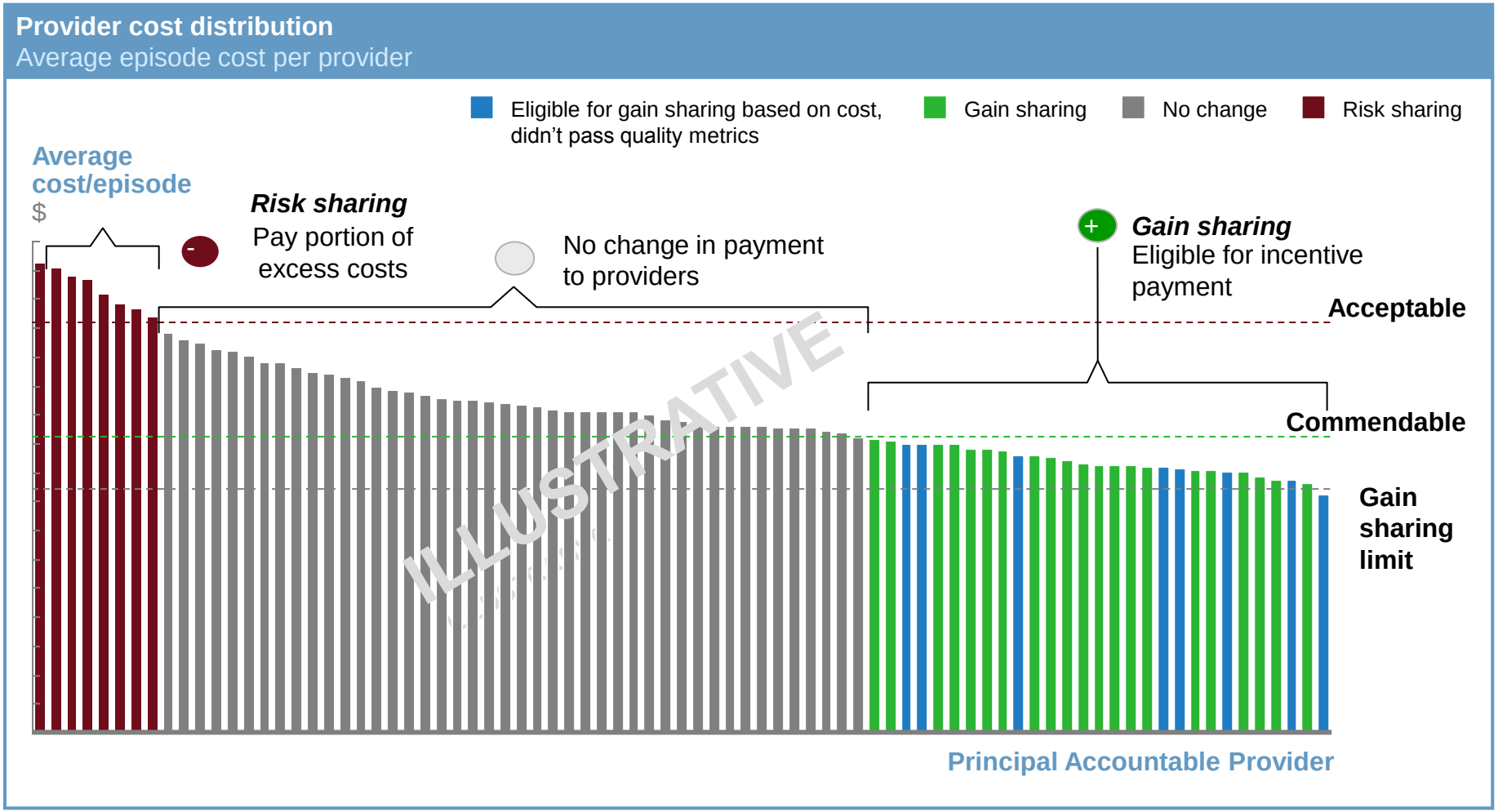
Compare average costs to predetermined ''commendable' and 'acceptable' levels[2]

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

Reward providers for delivering cost-efficient, high-quality care



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

SOURCE: Arkansas Payment Improvement Initiative

~50 – 70% of spend may be addressable through episodes

	Examples	Percent of total spend			
		Commercial	Medicaid	Medicare	
Prevention	Routine health screenings	~5	~5	~3-5	Addressed through population-based model (e.g., PCMH)
Chronic care (medical)	Diabetes, chronic CHF, CAD	~15-25	~10-15	~20-30	
Acute outpatient medical	Ambulatory URI, sprained ankle	~5-10	~5-10	~5-10	Potentially addressable through episodes (e.g., discrete, defined goal, clear guidelines)
Acute inpatient medical	CHF, pneumonia, AMI, stroke	~20-25	~5-15	~20-30	
Acute procedural	Hip/knee, CABG PCI, pregnancy	~25-35	~15-25	~20-25	
Cancer	Breast cancer	~10	<5	~10	
Behavioral health	ADHD, depression	~5	~15-20	~5	
Supportive care	Develop. disability, long-term care	N/A	~20-30	N/A	

Select episodes to pursue in the first year

Guiding principles for selection:

- Leverage episodes in flight elsewhere to **reduce time to launch**
- Prioritize meaningful **spend across payer populations**
- Select episodes that incorporate a **diverse mix** of accountable **providers** (e.g., facility, specialists)
- Cover a **diverse set of "patient journeys"** (e.g., acute inpatient, acute procedural, etc.)

Working hypothesis for episodes in first year:

- Perinatal
- Asthma acute exacerbation
- COPD exacerbation
- Joint replacement
- Percutaneous coronary intervention (PCI)

Next steps

- Refine episode and PCMH models in remaining workgroup conversations
- Continue to work through infrastructure requirements and approach in multi-payer meetings
- Support Governor in hosting Advisory Committee meeting in early October
- Submit SIM testing grant proposal
- Form and launch specific clinical workgroups for episode design

Ohio | Governor's Office of Health Transformation

Payment Innovation Task Force