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Transforming Payment for a Healthier Ohio

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Governor's Office of Health Transformation

Ohio Health Clinical Guidance Councils
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1. **Ohio's Vision for Health Transformation**
2. Paying for Value Instead of Volume
3. Patient-Centered Medical Home Model
4. Episode-Based Payment Model

2011 Ohio Crisis	vs.	Results Today
• $8 billion state budget shortfall		• Balanced budget
• 89-cents in the rainy day fund		• $1.5 billion in the rainy day fund
• Nearly dead last (48th) in job creation (2007-2009)		• Ranked 5th in the nation in job creation (2011-2013)
• Medicaid spending increased 9% annually (2009-2011)		• Medicaid spending increased 3% annually (2012-2013)
• Medicaid over-spending required multiple budget corrections		• Medicaid under-spending topped $950 million (2012-2013)
• Ohio Medicaid stuck in the past and in need of reform		• Ohio Medicaid looks to the future and embraces transformation
• More than 1.5 million uninsured Ohioans (75% of them working)		• Extended Medicaid coverage

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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

Governor Kasich's policy team preparing for Controlling Board, Oct. 16, 2013

Controlling Board testimony to extend Medicaid coverage, Oct. 21, 2013

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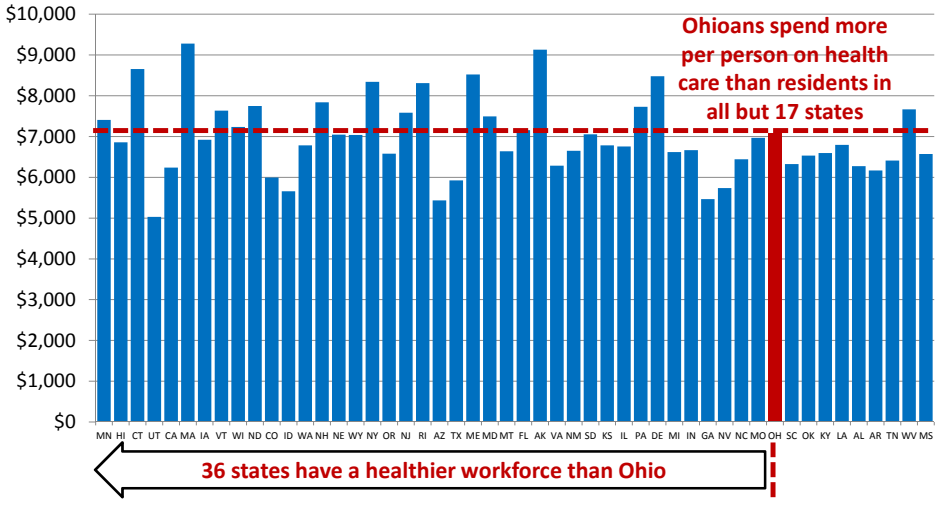
Health Care Spending per Capita by State (2011) in order of resident health outcomes (2009)



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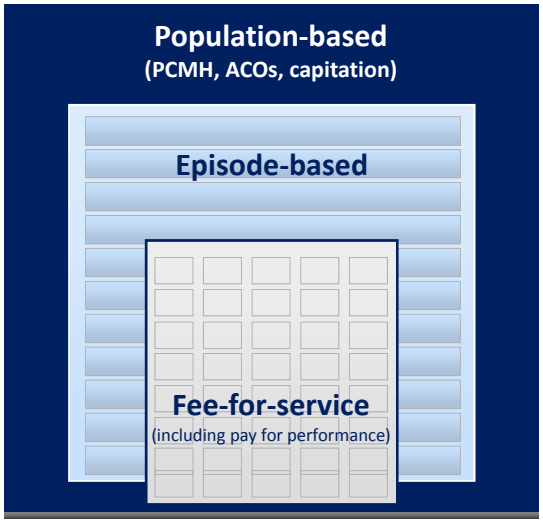
Sources: CMS *Health Expenditures by State of Residence* (2011); The Commonwealth Fund, *Aiming Higher: Results from a State Scorecard on Health System Performance* (October 2009).

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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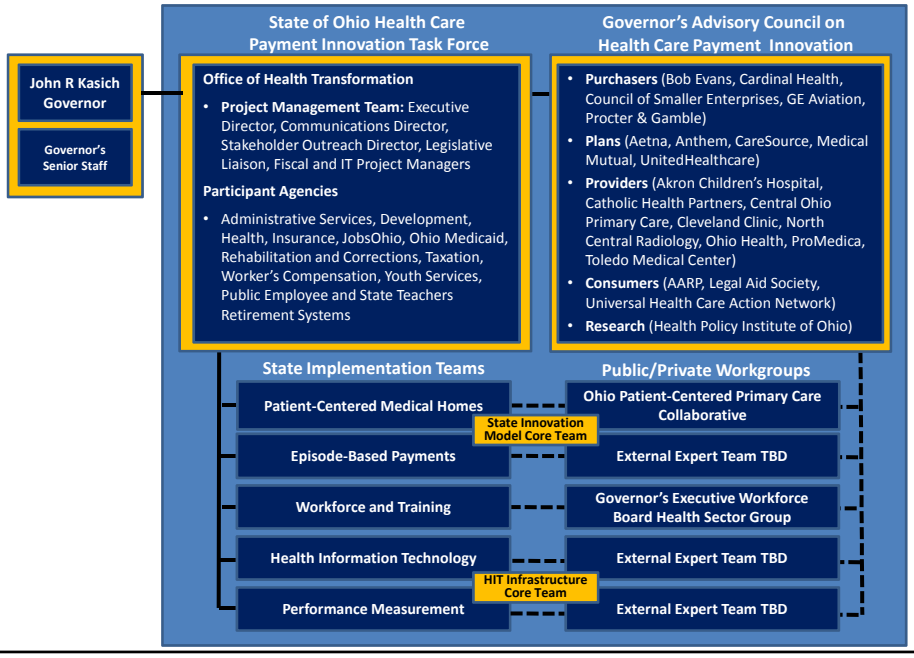

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5-Year Goal for Payment Innovation

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

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Scale is important to drive innovation

	What does scale mean?	Why is it important?
Provider 	▪ Meaningful portion (50% or more) of revenue tied to value for *individual* providers (e.g., hospitals, specialists, long-term services and supports, behavioral health)	▪ Supports shifts in individual provider practice patterns ▪ Drives towards improvements in operational efficiency
Regional 	▪ Substantial portion (>30%) of providers within a major *market* (e.g., Cleveland, Cincinnati, Columbus, Toledo) participate in new payment model	▪ Drives infrastructure development ▪ Supports holistic collaboration ▪ Practice patterns are rooted in medical community culture ▪ Delivers pressure from bottom-up on regulatory environment
State 	▪ Multiple markets within the state are transitioning to value-based payment models	▪ Supports major payors in state (including Medicare / Medicaid) to develop ability to support model at scale ▪ Influences state Medical school curriculums and related workforce initiatives

Agree on degrees of standardization within each model

"Standardize approach"	"Align in principle"	"Differ by design"
Standardize approach (i.e., identical design) only when: ▪ Alignment is critical to provider success or significantly eases implementation for providers (e.g., 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 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 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

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PCMH Model Design Team

Providers

- Michael Rothberg, MD, Cleveland Clinic
- Jeff Biehl, AccessHealth Columbus
- Richard Shonk, MD, Cincinnati Health Collaborative
- Ken Bertka, MD, Catholic Health Partners
- William Wulf, MD, Central Ohio Primary Care
- Bruce Vanderhoff, MD, OhioHealth
- Will Groneman, TriHealth Cincinnati
- Randy Wexler, MD, Ohio State University
- Jim Misak, MD, MetroHealth
- Randall Cebul, MD, Better Health Greater Cleveland
- Rita Horwitz, RN, Better Health Greater Cleveland
- Deborah Southard, Family Practice of SW Ohio
- William Washington, MD, Linden Medical Center
- Pamela Oatis, MD, St. Vincent Mercy Children's
- Susan Miller, PriMed Physicians
- Nick Lashutka, Ohio Children's Hospital Assoc.
- Robert Falcone, MD, Ohio Hospital Assoc.
- Berna Bell, Ohio Hospital Assoc.

Payers

- Robin Dawson, Medical Mutual
- Donald Wharton, MD, CareSource
- Randy Montgomery, Aetna
- Kelly Owen, Anthem
- Pam Schultz Anthem
- Richard Gajdowski, MD, United Healthcare
- Craig Osterhues, GE *(representing purchasers)*

State

- Ted Wymyslo, MD, ODH *(PCMH Team Chair)*
- Heather Reed, ODH
- Amy Bashforth, ODH
- Robyn Colby, Medicaid
- Debbie Saxe, Medicaid
- Angela Dawson, Minority Health Commission
- Angie Bergefurd, MHAS
- Afet Kilinc, MHAS
- Greg Moody, OHT
- Rick Tully, OHT
- Monica Juenger, OHT
- Marc Molea, Aging
- Rebecca Susteric, BWC
- McKinsey: Razili Stanke-Koch, Caroline Cross, Brendan Buescher, Kara Carter, Thomas Latkovic, Amit Shah, MD

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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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Ohio already has various PCMH projects underway

● Major focus of pilots
◐ Some focus
○ Minimal or no focus

	HB 198 Education Pilot Sites	NCQA, AAAHC, Joint Commission	Cincinnati/Dayton CPCi	Private Payer Pilots
	▪ 47 pilot sites target underserved areas ▪ Potential to add 50 pediatric pilots	▪ 291 NCQA-recognized sites ▪ 18 Joint Commission accredited sites ▪ 5 AAAHC-accredited	▪ 61 sites in OH (14 in KY), incl. Tri-Health, Christ Hospital, PriMed, Providence, St. Elizabeth (KY)	▪ Vary in scope by pilot, but tend to focus on larger independent or system-led practices
Care delivery model	●	●	●	●
Payment model	○	●	●	●
Infrastructure	◐	◐	●	◐
Scale-up and practice performance improvement	◐	◐	●	●

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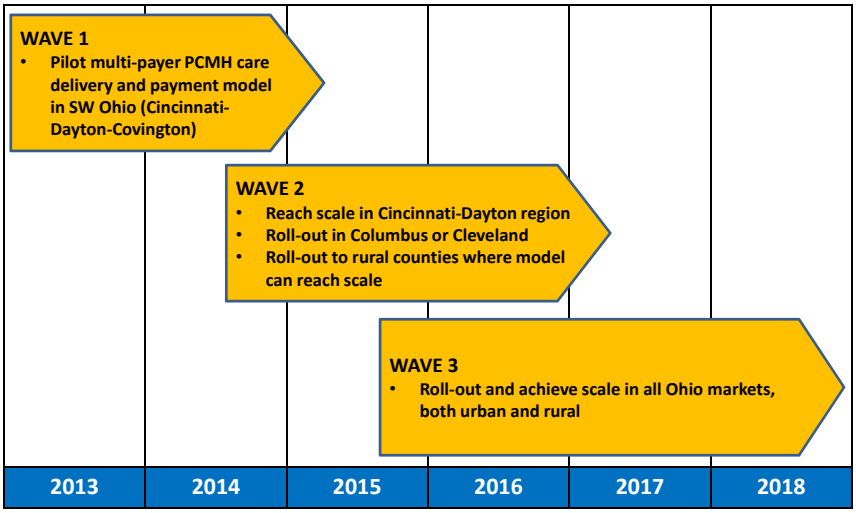
Source: Ohio Patient-Centered Primary Care Collaborative ; as of Oct. 2013.

CPC Informed Ohio's PCMH Model Design

		Standardize	Align in Principle	Differ by Design
Care Delivery Model	Target patients and scope		✓	
	Care delivery improvements		✓	
	Target sources of value		✓	
Payment Model	Technical require-ments for PCMH	✓		
	Attribution / assignment	✓		
	Quality measures	✓		
	Payment streams / incentives			✓
	Patient incentive		✓	

Check-mark indicates whether most design decisions will need to be standardized, aligned in principle, or differ by design. However, within any component of the model, there may be individual design decisions that fall into each bucket

Build Capacity to Roll Out PCMH Statewide



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Episode-Based Payment Model Design Team

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- David Bronson, MD, Cleveland Clinic
- Tony Hrudka, MD, Cleveland Clinic
- Michael McMillan, Cleveland Clinic
- John Corlett, MetroHealth
- Steve Marcus, ProMedica
- Terri Thompson, ProMedica
- John Kontner, OhioHealth
- Jennifer Atkins, Catholic Health Partners
- Ken Bertka, MD, Catholic Health Partners
- Richard Shonk, MD, Cincinnati Health Collaborative
- Mary Cook, MD, Central Ohio Primary Care
- Randall Cebul, MD, Better Health Greater Cleveland
- Rita Horwitz, RN, Better Health Greater Cleveland
- Uma Kotegal, MD, Cincinnati Children's Hospital
- Mary Wall, MD, North Central Radiology
- Michael Barber, MD, National Church Residences
- Todd Baker, Ohio State Medical Assoc.
- Nick Lashutka, Ohio Children's Hospital Assoc.
- Ryan Biles, Ohio Hospital Assoc.
- Alyson DeAngelo, Ohio Hospital Assoc.

Payers

- Wendy Payne, Medical Mutual
- Jim Peters, CareSource
- Ron Caviness, Aetna
- Barb Cannon, Anthem
- Meredith Day, Anthem
- Tammy Dawson, Anthem
- Mark DiCello, United Healthcare
- Rick Buono, United Healthcare
- Tim Kowalski, MD, Progressive *(representing purchasers)*

State

- John McCarthy, Medicaid *(Episode Team Chair)*
- Robyn Colby, Medicaid
- Patrick Beatty, Medicaid
- Debbie Saxe, Medicaid
- Ogbe Aideyman, Medicaid
- Mary Applegate, MD, Medicaid
- Katie Greenwalt, Medicaid
- Amy Bashforth, ODH
- Anne Harnish, ODH
- Mark Hurst, MD, MHAS
- Greg Moody, OHT
- Rick Tully, OHT
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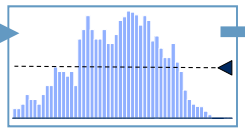
Retrospective episode model mechanics

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]



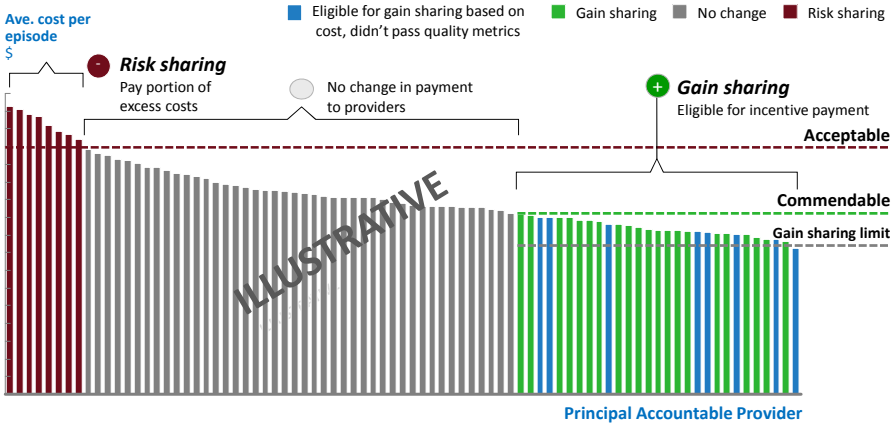
Compare average costs to predetermined ''commendable' and 'acceptable' levels[2]

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

Episode Algorithm Design Elements

Identify trigger and episode spend → Identify Primary Accountable Provider (PAP) → Remove Exclusions → Apply Risk Adjustment → Assess Quality Metrics

Example: Asthma Acute Exacerbation*

- *Trigger*
  - ED visit
  - IP admission
- *Pre-Trigger (none)*
- *Post-Trigger (30 days) includes relevant:*
  - Office visits
  - Labs
  - Medications
  - Readmissions
- ED facility or admitting facility
- Specific comorbidities
- Use of a vent
- ICU more than 72 hours
- Left AMA
- Death in hospital
- Under 5 years old
- Eligibility
- 9 risk factors
- Uses coefficients from AR model
- *Linked to gain sharing:*
  - Corticosteroid and/or inhaled corticosteroid use
  - Follow-up visit within 30 days
- *For reporting:*
  - Repeat acute exacerbation rate

Each episode algorithm is jointly developed with input from key stakeholders including providers (e.g., pulmonologists in this example) and payers

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* Algorithm currently in use by the Arkansas Payment Improvement Initiative

Selection of episodes in the first year

Guiding principles for selection:

- Leverage episodes in use elsewhere to **reduce time to launch**
- Prioritize meaningful **spend across payer populations**
- Look for opportunities with **clear sources of value** (e.g., high variance in care)
- 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)
- Consider **alignment with current priorities** (e.g., perinatal for Medicaid, asthma acute exacerbation for youth)

Working hypothesis for episodes in the first year:

- Perinatal
- Asthma acute exacerbation
- Chronic obstructive pulmonary disease (COPD) exacerbation
- Joint replacement
- Percutaneous coronary intervention (PCI)

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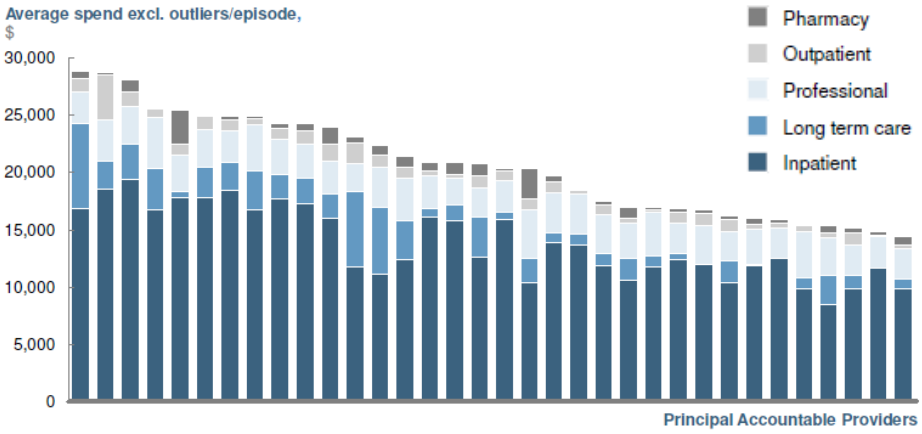
Preliminary Provider Summary: Total Joint Replacement Episode Distribution by Claim Type



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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.

Where we are in the episode design process

Episode design path	Design of overall model for the State Health Improvement Plan	Episode definitions	Payer specific episode design decisions
	Multi-payer agreement or 'charter' Medicaid 'strawman'	Perinatal Asthma/COPD exacerbation PCI Joint replacement	Customization & thresholding
Description	▪ Agreement on decisions for multi-payer alignment ▪ Working hypothesis for Medicaid; share w/ payers	▪ Clinical input on elements of episode definition (e.g., principal accountable provider)	▪ Work through payer specific elements (e.g., cost normalization)
Who's involved?	▪ Multi-payer Core team ▪ Payer / provider episode design group	▪ Clinical Advisory Group ▪ SIM Core team aligns on final definitions	▪ Internal state episode design team ▪ Individual payer design teams
Outputs	▪ Charter ▪ 3 – 5 year vision	▪ Detailed business requirements for each episode (e.g., code sets)	▪ Payer-specific episode algorithms

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Note: as of March 1, 2014.

SAMPLE Report:

Anthem
aetna
UnitedHealthcare
MEDICAL MUTUAL
CareSource
MOLINA HEALTHCARE
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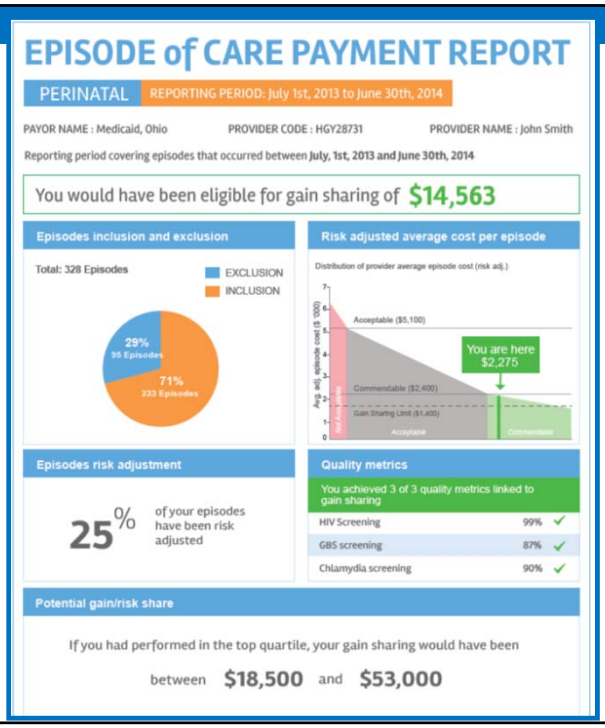

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- **Ohio's State Health Innovation Plan**
- **Multi-Payer PCMH Charter**
- **Multi-Payer Episode Charter**
- **Detailed Episode Definitions**