# **Ohio** Governor's Office of Health Transformation

# Transforming Payment for a Healthier Ohio

Greg Moody, Director Governor's Office of Health Transformation

Legislative Joint Medicaid Oversight Committee August 20, 2014

www.HealthTransformation.Ohio.gov

Ohio Governor's Office Health Transform			Innovatio	on Framework
Modernize Medicaid			mline Health and uman Services	Pay for Value
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# Ohio

#### Governor's Office of Health Transformation

### **Payment Innovation Partners**

#### John R Kasich Governor

Governor's Senior Staff

#### State of Ohio Health Care Payment Innovation Task Force

**Office of Health Transformation** 

 Project Management Team: Executive Director, Communications Director, Stakeholder Outreach Director, Legislative Liaison, Fiscal and IT Project Managers

#### **Participant Agencies**

 Administrative Services, Development, Health, Insurance, JobsOhio, Ohio Medicaid, Rehabilitation and Corrections, Taxation, Worker's Compensation, Youth Services, Public Employee and State Teachers Retirement Systems

#### Governor's Advisory Council on Health Care Payment Innovation

- Purchasers (Bob Evans, Cardinal Health, Council of Smaller Enterprises, GE Aviation, Procter & Gamble, Progressive)
- **Plans** (Aetna, Anthem, CareSource, Medical Mutual, UnitedHealthcare)
- Providers (Akron Children's Hospital, Catholic Health Partners, Central Ohio Primary Care, Cleveland Clinic, North Central Radiology, Ohio Health, ProMedica, Toledo Medical Center)
- Consumers (AARP, Legal Aid Society, Universal Health Care Action Network)
- Research (Health Policy Institute of Ohio)





### 1. Ohio Approach to Paying for Value Instead of Volume

- 2. Patient-Centered Medical Home Model
- 3. Episode-Based Payment Model

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



### 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



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Source: UnitedHealth, Farewell to Fee-for-Service: a real world strategy for health care payment reform (December 2012)



# 27 states are designing and testing payment innovation programs





Governor's Office of Health Transformation SIM: State Innovation Model; CPCI: Comprehensive Primary Care Initiative SOURCE: U.S. Centers for Medicare and Medicaid Services (CMS).

### 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



#### **Ohio** Governor's Office of Health Transformation 5-Year Goal for Payment Innovation

Goal State's Role	<ul> <li>80-90 percent of Ohio's population in some value-based payment model (combination of episodes- and population-based payment) within five years</li> <li>Shift rapidly to PCMH and episode model in Medicaid fee-for-service</li> <li>Require Medicaid MCO partners to participate and implement</li> <li>Incorporate into contracts of MCOs for state employee benefit program</li> </ul>		
	Patient-centered medical homes	Episode-based payments	
Year 1	<ul> <li>In 2014 focus on Comprehensive Primary Care Initiative (CPCi)</li> <li>Payers agree to participate in design for elements where standardization and/or alignment is critical</li> <li>Multi-payer group begins enrollment strategy for one additional market</li> </ul>	<ul> <li>State leads design of five episodes: asthma acute exacerbation, perinatal, COPD exacerbation, PCI, and joint replacement</li> <li>Payers agree to participate in design process, launch reporting on at least 3 of 5 episodes in 2014 and tie to payment within year</li> </ul>	
Year 3	<ul> <li>Model rolled out to all major markets</li> <li>50% of patients are enrolled</li> </ul>	<ul> <li>20 episodes defined and launched across payers</li> </ul>	
Year 5	<ul> <li>Scale achieved state-wide</li> <li>80% of patients are enrolled</li> </ul>	<ul> <li>50+ episodes defined and launched across payers</li> </ul>	

### **Ohio's Health Care Payment Innovation Partners:**





















- 1. Ohio Approach to Paying for Value Instead of Volume
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### Why the Medical Home Works: A Framework

Feature	Definition	Sample Strategies	Potential Impacts
Patient-Centered	Supports patients and families to manage & organize their care and participate as fully informed partners in health system transformation at the practice, community, & policy levels	<ul> <li>Dedicated staff help patients navigate system and create care plans</li> <li>Focus on strong, trusting relationships with physicians &amp; care team, open communication about decisions and health status</li> <li>Compassionate and culturally sensitive care</li> </ul>	Patients are more likely to seek the right care, in the right place, and at the right time
Comprehensive	A team of care providers is wholly accountable for patient's physical and mental health care needs – includes prevention and wellness, acute care, chronic care	<ul> <li>Care team focuses on 'whole person' and population health</li> <li>Primary care could co-locate with behavioral or oral health, vision, OB/GYN, and pharmacy</li> <li>Special attention is paid to chronic disease and complex patients</li> </ul>	Patients are less likely to seek care from the emergency room or hospital, and delay or leave conditions untreated
Coordinated	Ensures care is organized across all elements of broader health care system, including specialty care, hospitals, home health care, community services, & public health	<ul> <li>Care is documented and communicated effectively across providers and institutions, including patients, primary care, specialists, hospitals, home health, etc.</li> <li>Communication and connectedness is enhanced by health information technology</li> </ul>	Providers are less likely to order duplicate tests, labs, or procedures Better management of chronic diseases and other illness
Accessible	Delivers consumer-friendly services with shorter wait-times, extended hours, 24/7 electronic or telephone access, and strong communication through health IT innovations	<ul> <li>More efficient appointment systems offer same-day or 24/7 access to care team</li> <li>Use of e-communications and telemedicine provide alternatives for face-to-face visits and allow for after hours care</li> </ul>	improves health outcomes Focus on wellness and prevention reduces incidence / severity of chronic disease and illness
Committed to quality and safety	Demonstrates commitment to quality improvement through use of health IT and other tools to ensure patients and families make informed decisions	<ul> <li>EHRs, clinical decision support, medication management improve treatment &amp; diagnosis.</li> <li>Clinicians/staff monitor quality improvement goals and use data to track populations and their quality and cost outcomes</li> </ul>	Cost savings result from: • Appropriate use of medicine • Fewer avoidable ER visits, hospitalizations, & readmissions

Source: Patient-Centered Primary Care Collaborative (2014)

### **PCMH Care Delivery Improvements**

- Risk-stratified care management (care plans, patient riskstratification registry)
- Access and continuity of care (team-based care, multi-channel access, 24/7 access, same day appointments, electronic access)
- Planned care for chronic conditions and preventive care
- Patient and caregiver engagement (shared decision-making, more time discussing patient's conditions and treatment options)
- Coordination of care across the medical neighborhood (follow up on referrals, integrate behavioral and physical health needs, coordinate with all forms of insurance including BWC)



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### **PCMH Payment Incentives**

- Payers agree to provide resources to support business model transformation for a finite period of time, particularly for small, less capitalized practices
- Agree to provide resources to compensate PCMH for activities not fully covered by existing fee schedules (care coordination, non-traditional visits like telemedicine, population health)
- Agree to reward PCMHs for favorably affecting risk-adjusted total cost of care over time by offering bonus payments, shared savings, capitation, or sub-capitation.



### **Benefits of Implementing a PCMH**

РСМН	Fewer ED visits	Fewer Hospital Admissions	Cost savings
Alaska Medical Center	50%	53%	
Capital Health Plan, FL	37%		18% lower claims costs
Geisinger Health System, PA		25%	7% lower total spending
Group Health of Washington		15%	\$15 million (2009-2010)
HealthPartners, MI	39%	40%	
Horizon BCBS, NJ		21%	
Maryland CareFirst BCBS			\$40 million (2011)
Vermont Medicaid	31%		22% lower PMPM (2008-2010)



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Source: Patient-Centered Primary Care Collaborative, "Benefits of Implementing the PCMH: A Review of Cost and Quality Results (2012)



### **Comprehensive Primary Care Initiative**

- Dayton/Cincinnati is one of only seven CPCI sites nationally
- Bonus payments to primary care doctors who better coordinate care
- Multi-payer: Medicare, Medicaid, nine commercial insurance plans
- 75 primary care practices (261 providers) serving 44,500 Medicare enrollees in 14 Ohio and 4 Kentucky counties
- Practices were selected based on their use of HIT, advanced primary care recognition, and participation in practice improvement activities
- Supported by a unique regional collaborative: The Greater Cincinnati Health Council, the Health Collaborative, and HealthBridge



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Source: <u>www.innovations.cms.gov/initiatives/Comprehensive-Primary-</u> <u>Care-Initiative/Ohio-Kentucky</u>



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#### State's Role

Goal

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- Require Medicaid MCO partners to participate and implement
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### **Retrospective episode model mechanics**

Patients and providers continue to deliver care as they do today



and select providers as they do today



**Providers** submit claims as they do today



**Payers** reimburse for all services as they do today

Calculate incentive payments based on outcomes after close of 12 month performance period A view 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<sup>1</sup>



**Compare average costs** to predetermined "commendable' and 'acceptable' levels<sup>2</sup>



- 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





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

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



Principal Accountable Providers

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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.

### 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
- Acute and non-acute percutaneous coronary intervention (PCI)





### UnitedHealthcare











## This is a sample report; the actual report is under development



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### **EPISODE of CARE PAYMENT REPORT**

#### PERINATAL REPORTING PERIOD: July 1st, 2013 to June 30th, 2014

PAYOR NAME : Medicaid, Ohio

PROVIDER CODE : HGY28731

PROVIDER NAME : John Smith

Reporting period covering episodes that occurred between July, 1st, 2013 and June 30th, 2014

#### You would have been eligible for gain sharing of \$14,563





### Ohio is ready to test its model

Timeline

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

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5/22/14 – Federal announcement

6/6/14 – Ohio letter of intent to apply

7/21/14 – Round 2 application due

10/31/14 – Anticipated notice of award

1/1/15-12/31/18 – Performance period

SOURCE: CMS Funding Opportunity Announcement (May 22, 2014)

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BUDGETS

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NEWSROOM CONTACT VIDEO



#### Current Initiatives

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

Implement a new Medicaid claims payment system Create a cabinet-level Medicaid department Consolidate mental health and addiction services Simplify and integrate eligibility determination Coordinate programs for children Share services across local jurisdictions

#### Pay for Value

Engage partners to align payment innovation Provide access to patient-centered medical homes Implement episode-based payments Coordinate health information technology infrastructure Coordinate health sector workforce programs Support regional payment reform initiatives Federal Health Insurance Exchange

- **Ohio's Innovation** • **Model Test Grant** Application
- **Multi-Payer PCMH** • Charter
- **Multi-Payer Episode** Charter
- **Detailed Episode Definitions**

Ohio's Innovation Model

- 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 ...

