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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

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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

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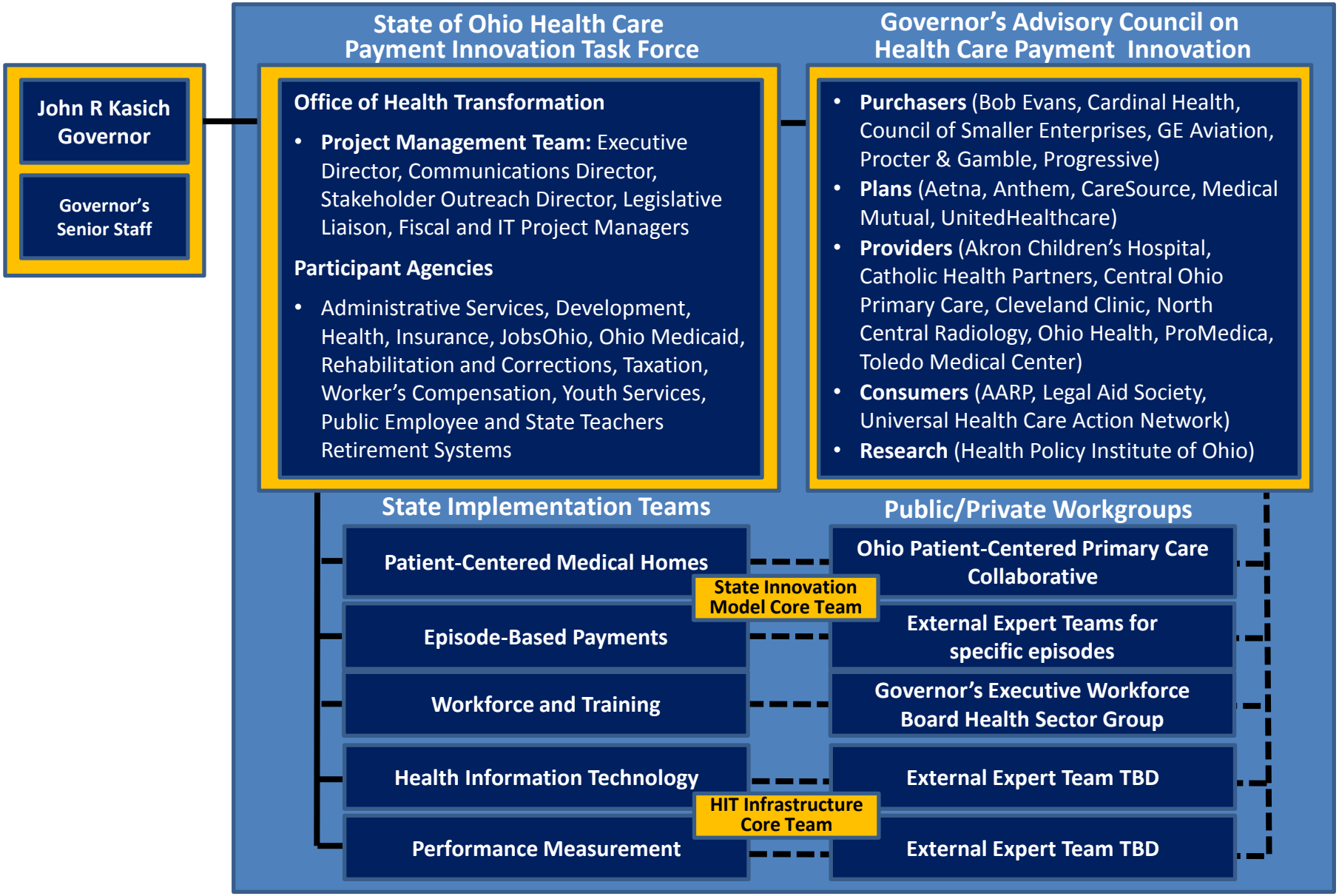
Payment Innovation Partners



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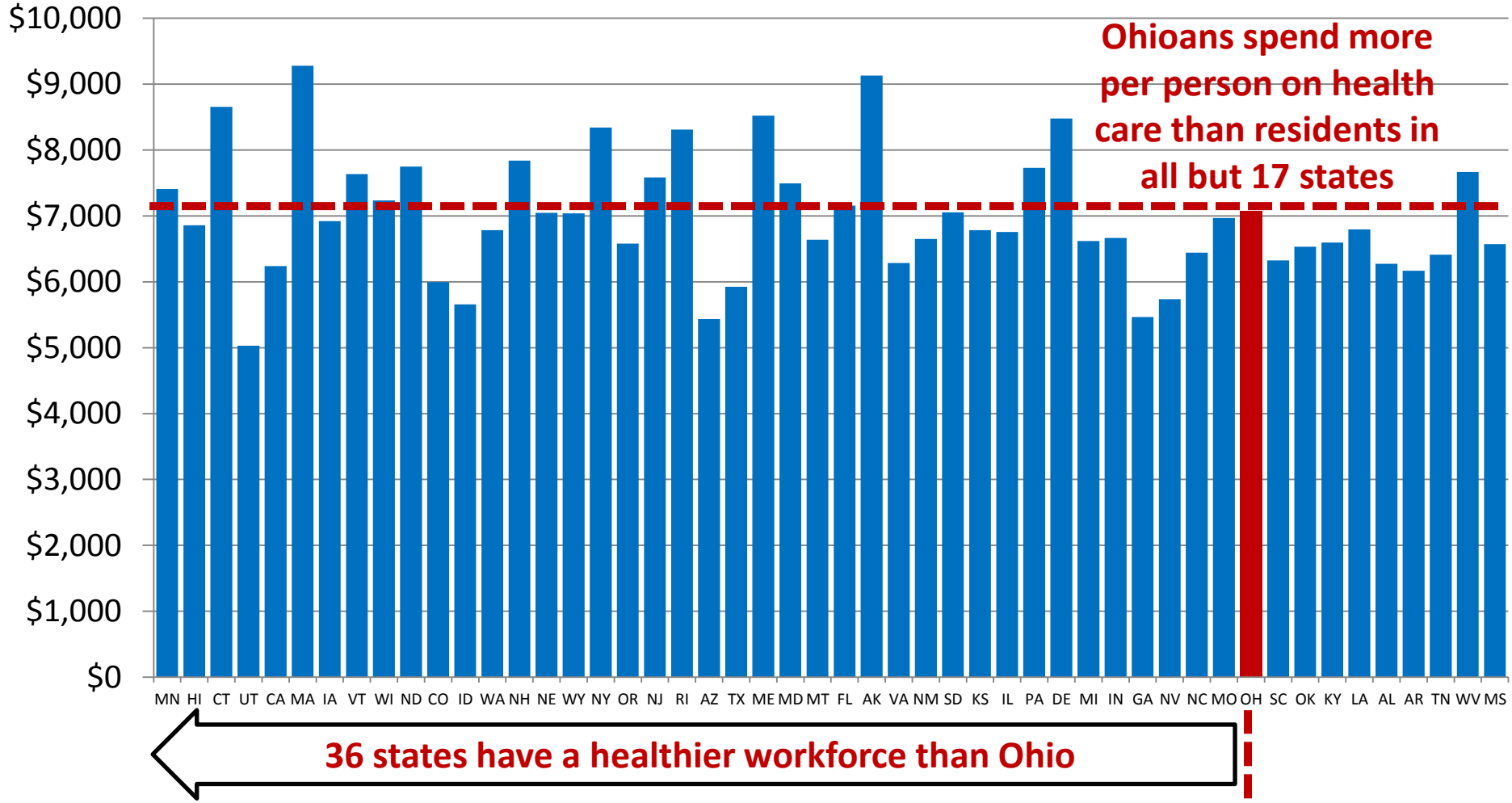
1. Ohio Approach to Paying for Value Instead of Volume
2. Patient-Centered Medical Home Model
3. Episode-Based Payment Model

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



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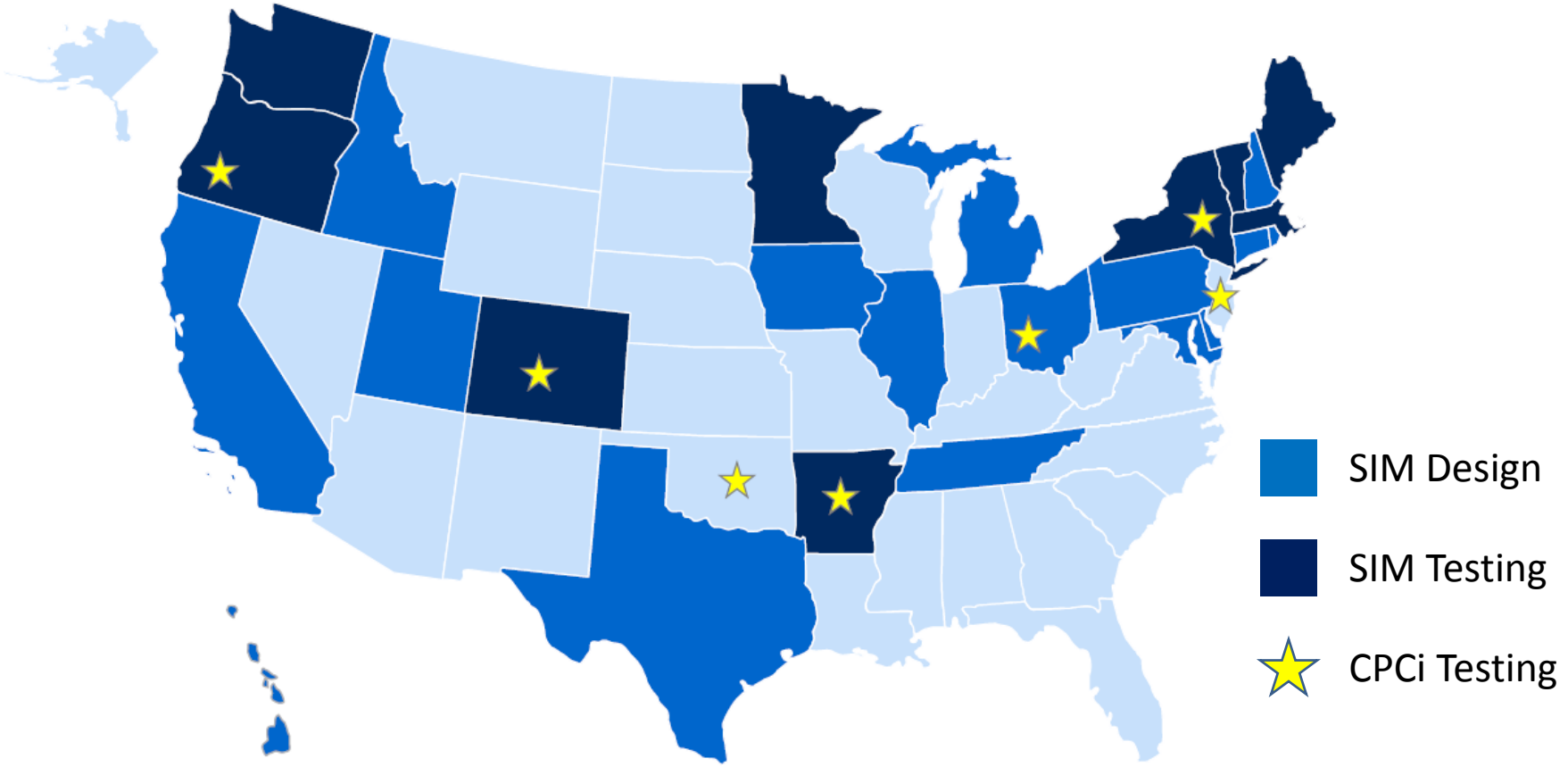
Sources: CMS *Health Expenditures by State of Residence* (2011); The Commonwealth Fund, *Aiming Higher: Results from a State Scorecard on Health System Performance* (October 2009).

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

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



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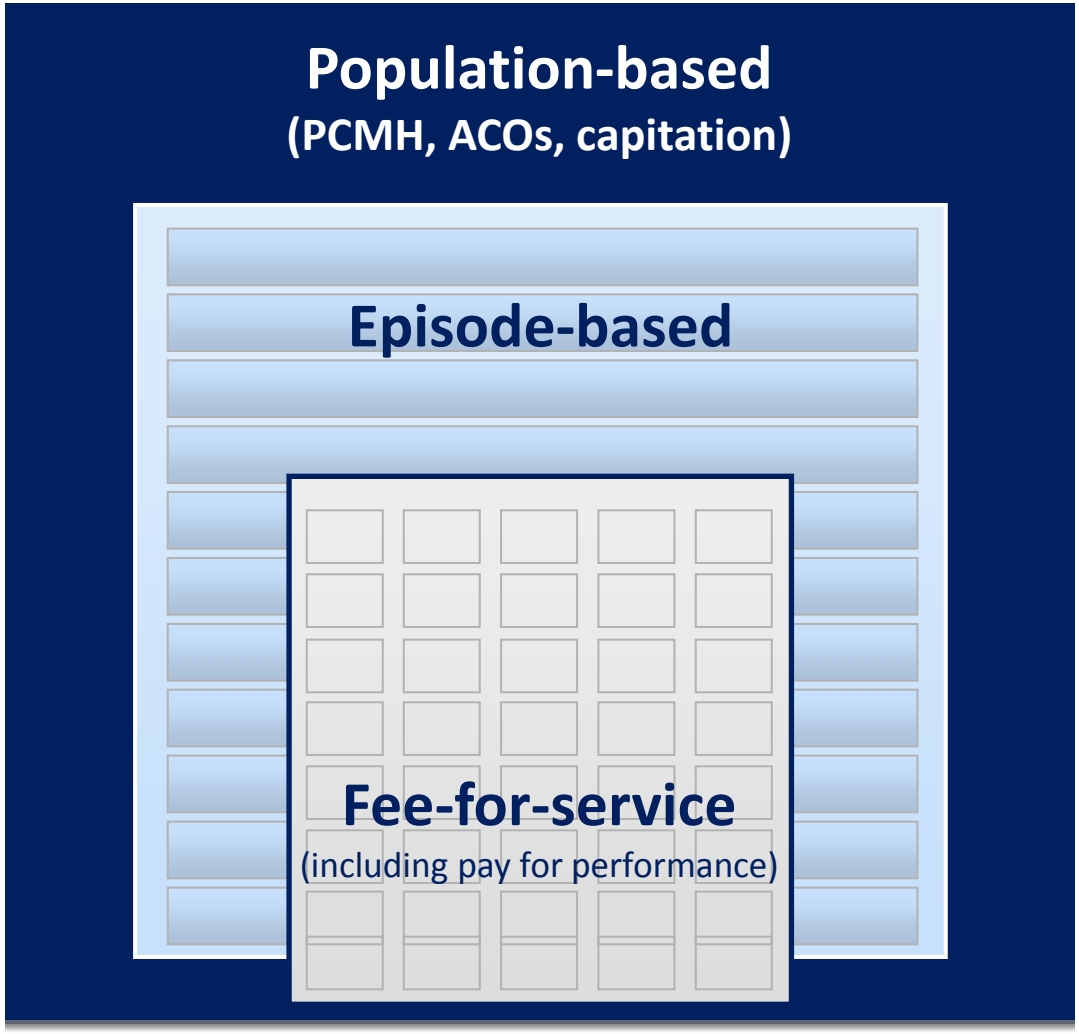
SIM: State Innovation Model; CPCI: Comprehensive Primary Care Initiative
SOURCE: U.S. Centers for Medicare and Medicaid Services (CMS).

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

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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

MOLINA HEALTHCARE

CareSource

Buckeye Community Health Plan

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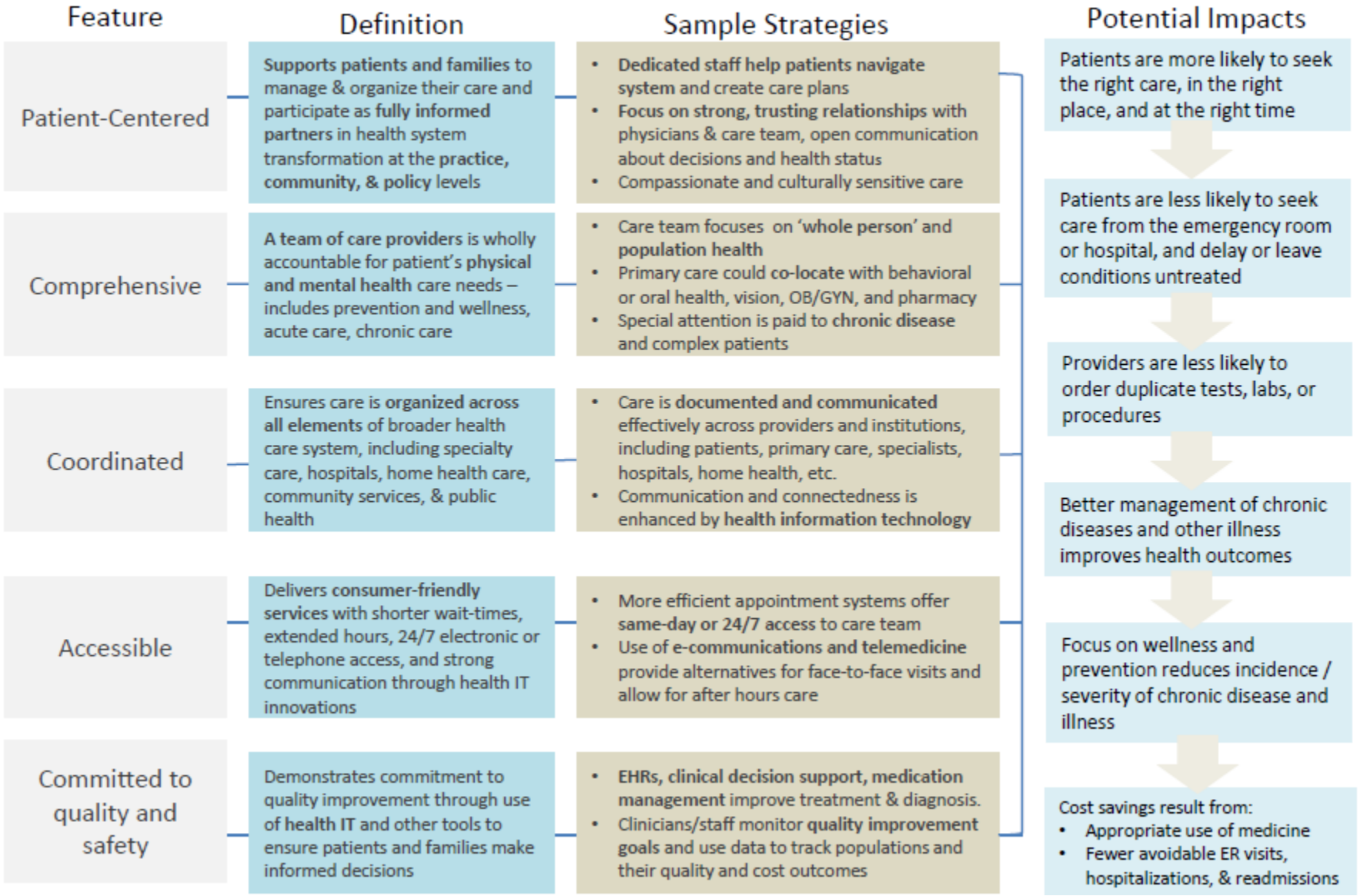
Why the Medical Home Works: A Framework



Source: Patient-Centered Primary Care Collaborative (2014)

PCMH Care Delivery Improvements

- Risk-stratified care management (care plans, patient risk-stratification 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)

Source: Ohio PCMH Multi-Payer Charter (2013)

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.

Source: Ohio PCMH Multi-Payer Charter (2013)

Benefits of Implementing a PCMH

PCMH	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)

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

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

Regional Health Improvement Collaboratives

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5-Year Goal for Payment Innovation

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5-Year Goal for Payment Innovation

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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

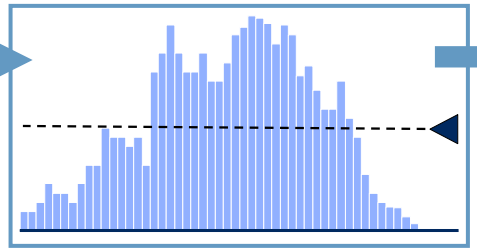
Payers reimburse for all services as they do today

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]



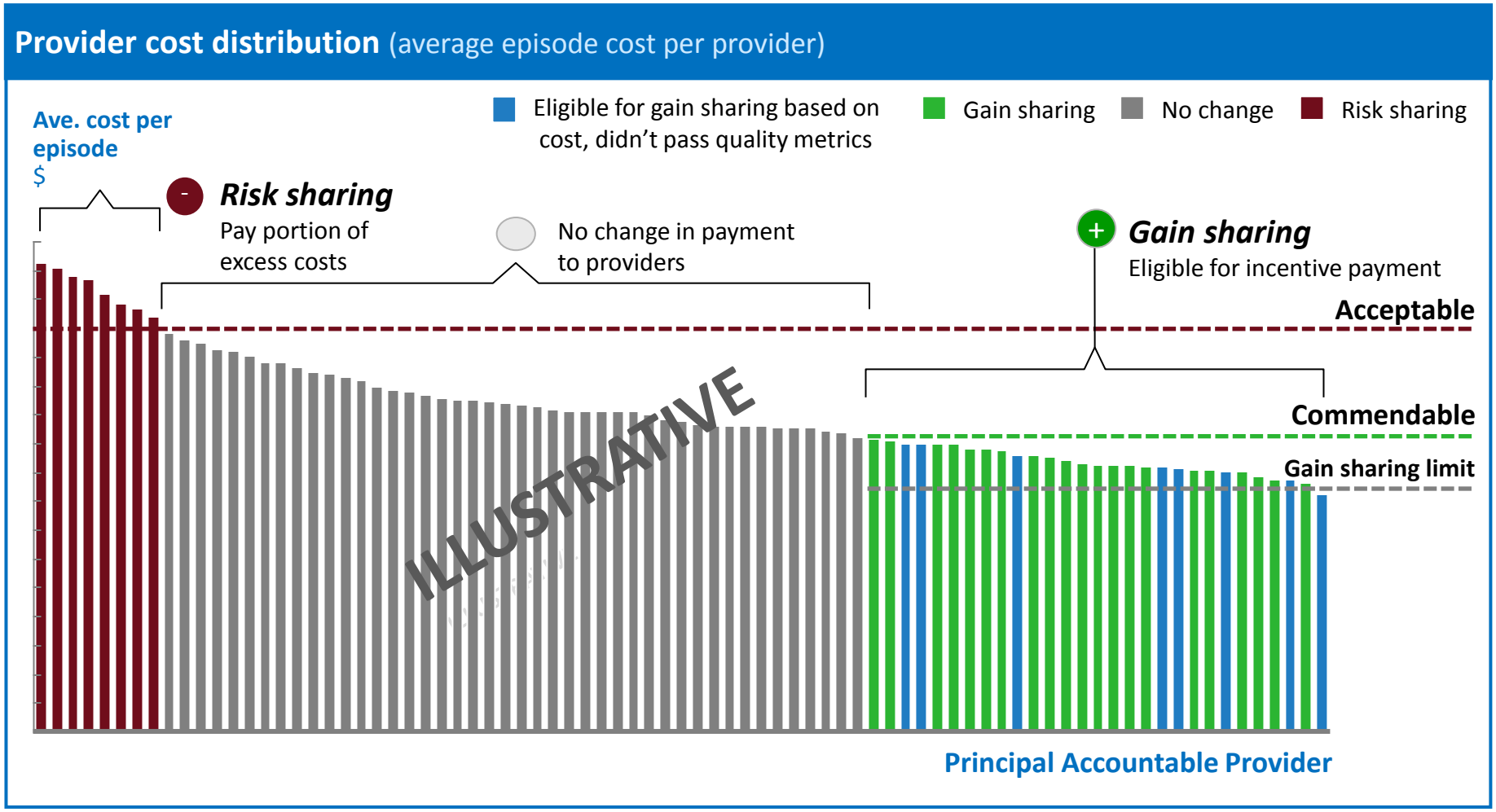
Compare average costs to predetermined ''commendable' and 'acceptable' levels[2]

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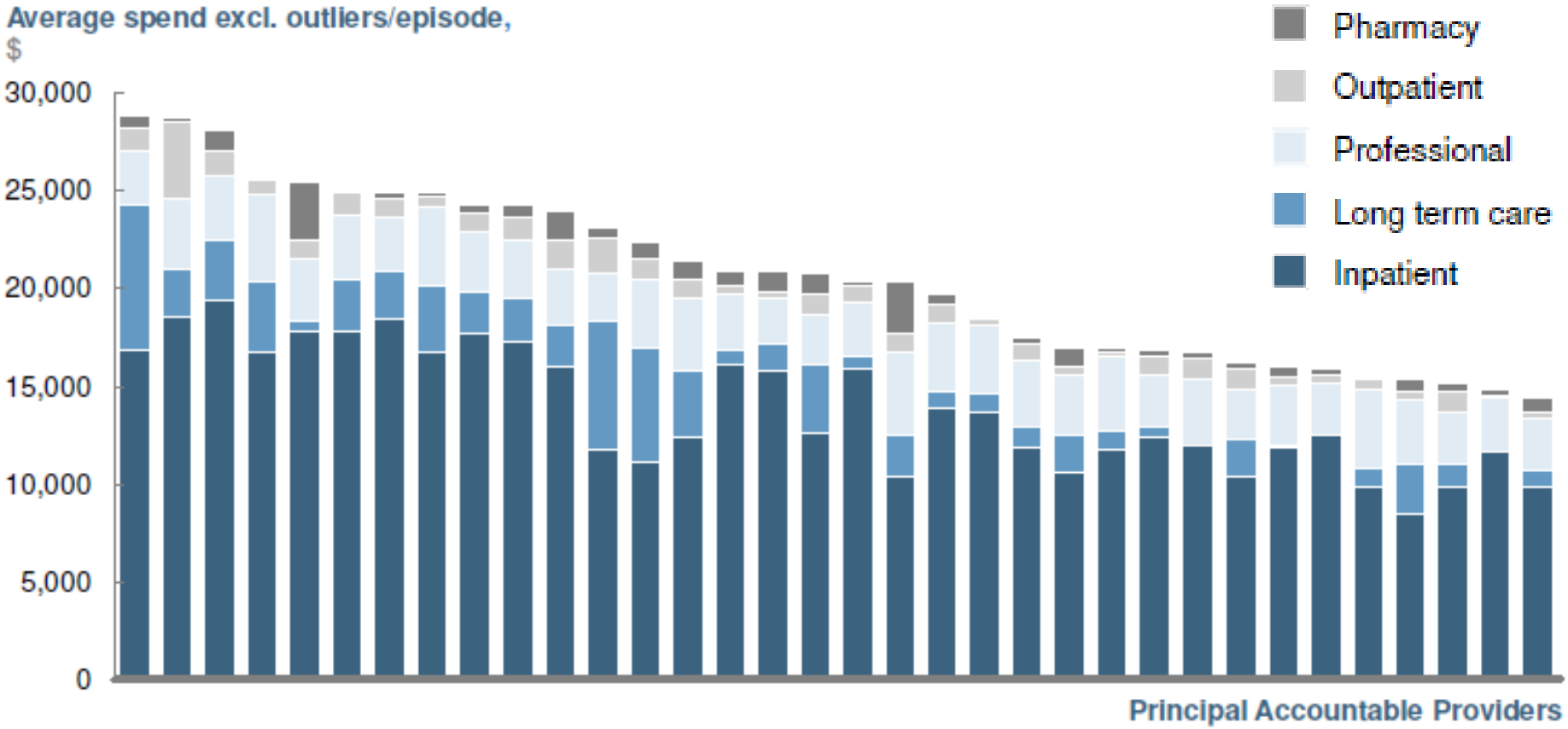
SOURCE: Arkansas Payment Improvement Initiative; each vertical bar represents the average cost for a provider, sorted from highest to lowest average cost

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



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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)

Anthem

aetna

UnitedHealthcare

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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

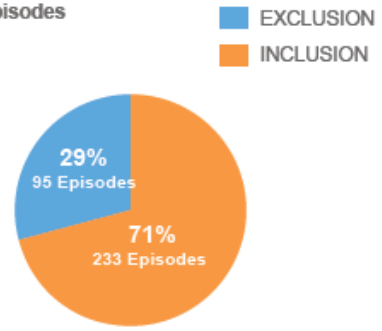
PAYOR NAME : Medicaid, Ohio PROVIDER CODE : HGY28731 PROVIDER NAME : John Smith

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**

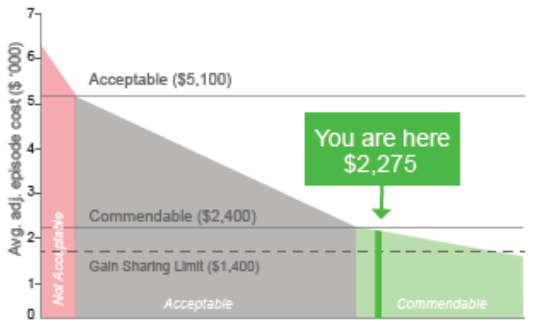
Episodes inclusion and exclusion

Total: 328 Episodes



Risk adjusted average cost per episode

Distribution of provider average episode cost (risk adj.)



Episodes risk adjustment

25% of your episodes have been risk adjusted

Quality metrics

You achieved 3 of 3 quality metrics linked to gain sharing

HIV Screening	99%	✓
GBS screening	87%	✓
Chlamydia screening	90%	✓

Potential gain/risk share

If you had performed in the top quartile, your gain sharing would have been

between **$18,500** and **$53,000**

Ohio is ready to test its model

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

Timeline

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

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

www.healthtransformation.ohio.gov

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CURRENT INITIATIVES | BUDGETS | NEWSROOM | CONTACT | VIDEO

Current Initiatives

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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
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Enhance community developmental disabilities services
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Streamline Health and Human Services
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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**

- 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 …