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Transforming Payment for a Healthier Ohio

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Ohio Association of Health Plans Annual Convention
May 25, 2016

www.HealthTransformation.Ohio.gov

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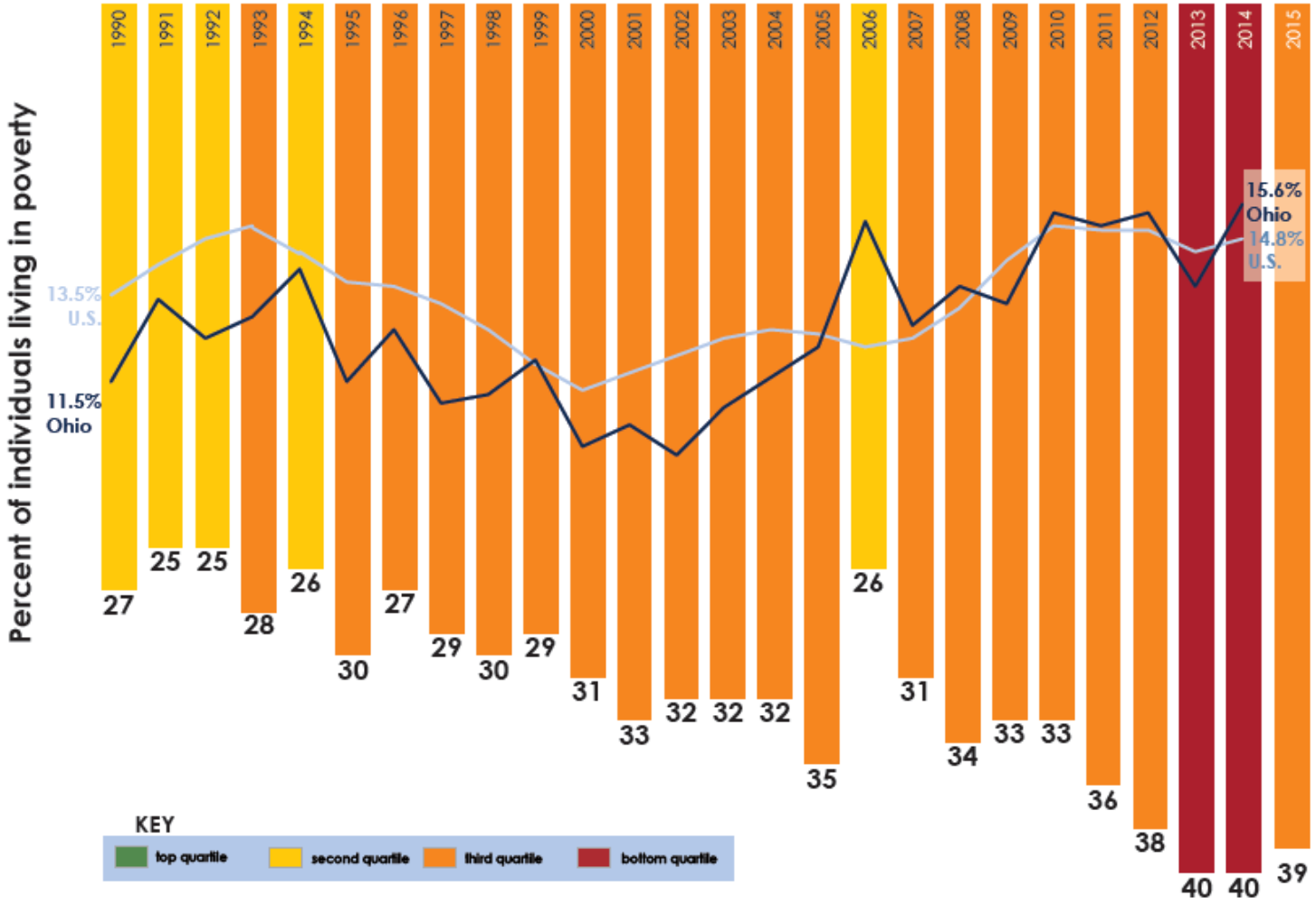
OHT Initiatives in 2016

1. Align population health planning infrastructure
2. Increase access to patient-centered medical homes
3. Redesign Medicaid behavioral health benefits
4. Redesign developmental disabilities services
5. Simplify disability determination

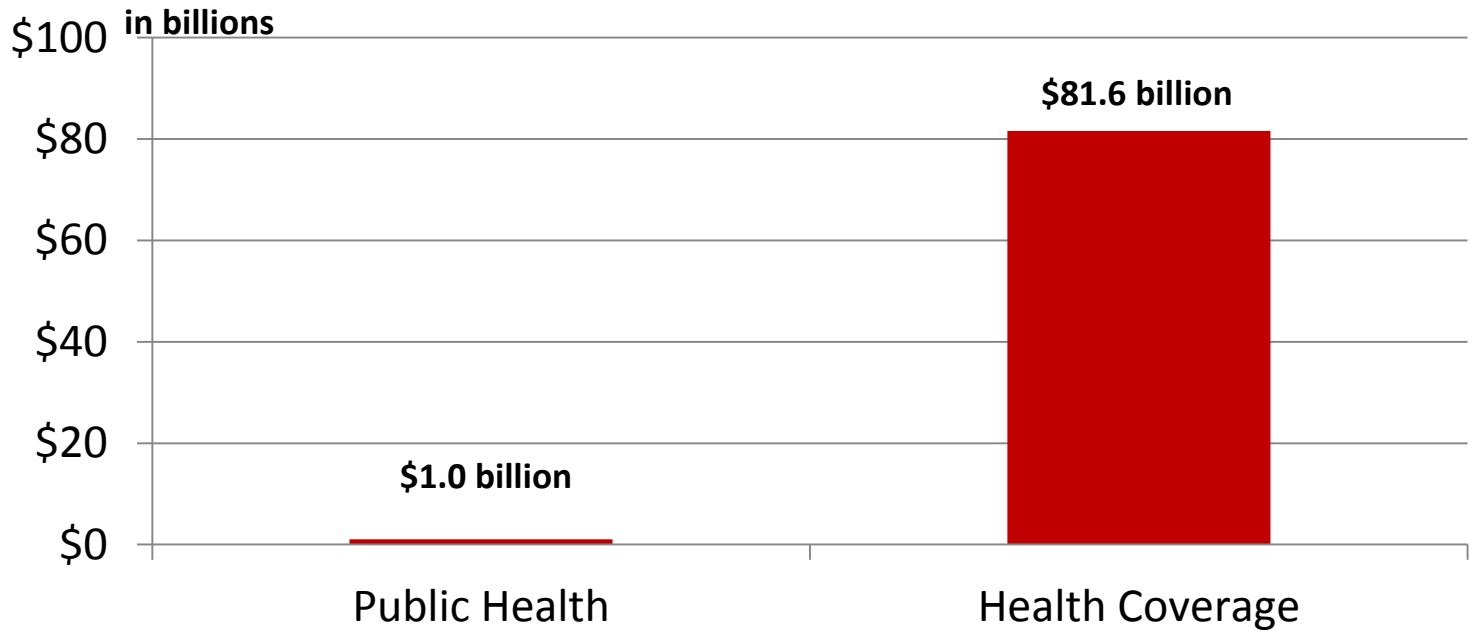
Ohio's performance on population health outcomes has steadily declined relative to other states



Source: Table prepared by the **Health Policy Institute of Ohio** based on United Health Foundation America's Health Rankings and U.S. Census Bureau Current Population Survey data.

Public health strategies alone are not sufficient

	Public Health	Health Coverage
State	State Health Improvement Plan	State Innovation Model Population Health Plan



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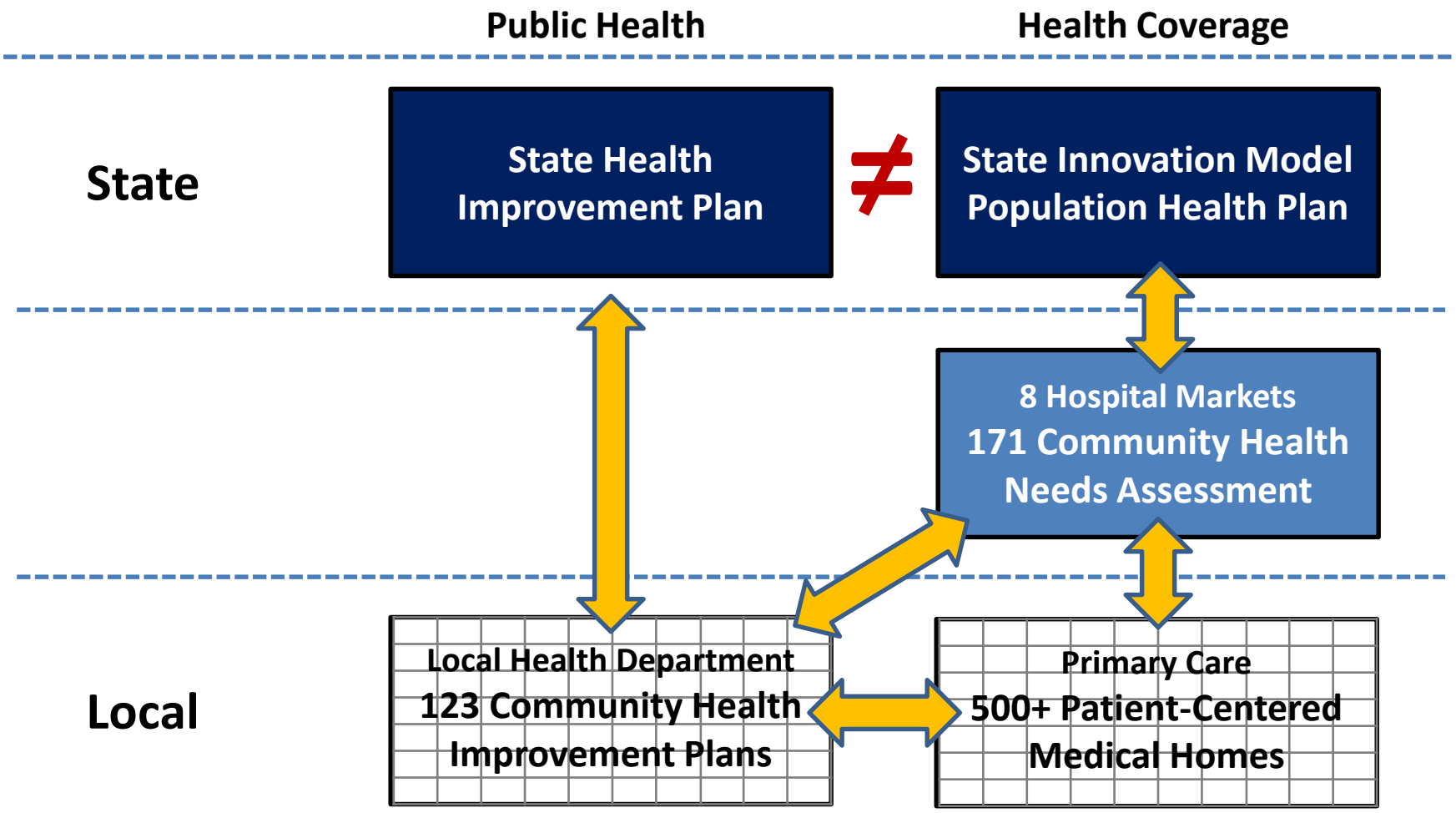
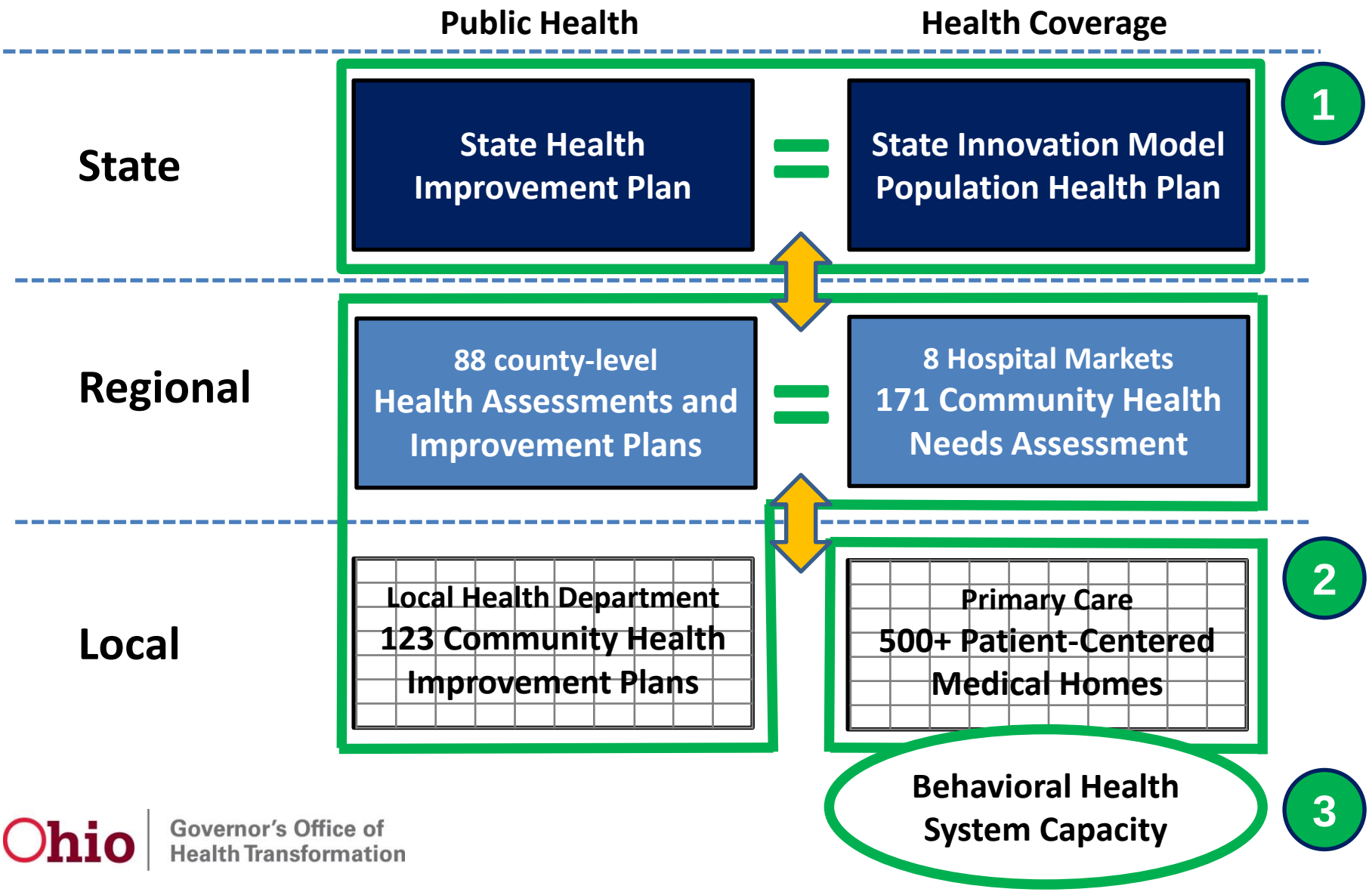
Source: "Public Health" includes $407 million federal, $188 million state, and $440 million local funds, Ohio Department of Health Annual Report (2015); "health coverage" includes total all payers by state of residence, CMS National Health Expenditure Data (2009)

The current system is misaligned …



Aligning Ohio's capacity to improve population health



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1

Improve state-level health improvement planning

- State health departments are required to develop a state health assessment (SHA) and improvement plan (SHIP) for accreditation by the Public Health Accreditation Board (PHAB)
- The Ohio Department of Health (ODH) was accredited by PHAB in December 2015 and will update Ohio's SHA and SHIP in 2016
- ODH contracted with HPIO to organize, facilitate and mentor stakeholders through a collaborative planning process leading to an exemplary SHA and SHIP that meet PHAB standards
- The updated SHIP will be used to set population health priorities – and target resources – across all state agencies

1

Align local population health planning infrastructure

- Local health districts must be PHAB accredited by 2020 and complete a community health assessment (CHA) and adopt an implementation plan (CHIP) every five years
- Tax-exempt 501(c)(3) hospital organizations are required by the IRS to conduct a community health needs assessment (CHNA) and adopt an implementation strategy (IS) every three years
- Requirements for these plans are similar but timelines and activities to conduct assessments and adopt plans often are not aligned, resulting in a lack of clearly defined priorities
- ODH will publish guidance for collaboration on community health assessments and improvement plans and introduce legislation that requires hospitals and health districts to use the same three-year planning timeline and publicly report improvement plans

2

Increase access to patient-centered medical homes

- Ohio was awarded a State Innovation Model (SIM) grant in 2014 to test health care payment models that reward better health outcomes and cost savings through improvement
- SIM creates an opportunity to incorporate population health priorities into the same performance measures that health care payers use to reward provider performance
- OHT and HPIO worked with clinicians and community health leaders to identify a core set of measures that are powerful for driving population health priorities *and* quality in primary care
- Ohio's largest health insurance plans have agreed to adopt a patient-centered medical home model that links the core measures to performance payments beginning in January 2018

Ohio's PCMH Requirements and Payment Streams

Requirements	1 8 activity requirements	2 5 Efficiency measures	3 20 Clinical Measures	4 Total Cost of Care
	▪ *Same-day appointments* ▪ *24/7 access to care* ▪ *Risk stratification* ▪ *Population management* ▪ *Team-based care management* ▪ *Follow up after hospital discharge* ▪ *Tracking of follow up tests and specialist referrals* ▪ *Patient experience*	▪ *ED visits* ▪ *Inpatient admissions for ambulatory sensitive conditions* ▪ *Generic dispensing rate of select classes* ▪ *Behavioral health related inpatient admits* ▪ *Episodes-linked metric*	▪ *Clinical measures aligned with CMS/AHIP core standards for PCMH*	

Enhanced payments begin January 1, 2018 for any PCP that meets the requirements

Payment Streams				
PMPM	***Scoring weight shifts from standard processes and activities…***		***…to efficiency and clinical quality over time***	
Shared Savings	***Must meet activity and efficiency targets***		***Quality gate***	***Based on self-improvement & performance relative to peers***

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Application Process for CPC+

April 15 – June 8

Payers submit applications

- Preference given to CPCi and MAPCP participants, and Medicaid SIM states
- States may need additional waivers/ SPAs to appy
- **State created a template for payers to apply**

June 8 – July 15

20 Regions Selected

- CMS evaluates payers and selects regions based on payer footprint
- 20 regions to be selected – intent to award to the 7 current CPCi regions plus 13 new regions
- Regional size and boundaries to be determined

July 15 – Sept. 1

Practices submit applications

- Practices in selected regions eligible to apply
- Application includes program integrity check, questions regarding care model, and letters of support including from IT vendor
- **State will create a template for practices to apply**

Sept. 1 – Dec. 31

5,000 practices selected

- Evaluation based on practice diversity (e.g., size, location)
- CMS-selected practices eligible for CPC+ Medicare payments beginning January 1, 2017

Ohio's episode timeline

Wave 1

Perinatal, asthma exacerbation, COPD exacerbation, Acute PCI, Non-acute PCI, total joint replacement

Design | Reporting only | Performance Y1 | Performance Y2 | Performance Y3

Wave 2

URI, UTI, cholecystectomy, appendectomy, upper GI endoscopy, colonoscopy, GI hemorrhage

Design | Reporting only | Performance Y1 | Performance Y2

Wave 3

Preliminary: HIV, Hepatitis C, Neonatal, Hysterectomy, Bariatric surgery, Diabetic ketoacidosis, Lower back pain, Headache, CABG, Cardiac valve, congestive heart failure, Breast biopsy, Breast cancer, Mastectomy, Otitis, Simple pneumonia, Tonsillectomy, Shoulder sprain, Wrist sprain, Knee sprain, Ankle sprain, Hip/Pelvic fracture, Knee arthroscopy, Lumbar laminectomy, Spinal fusion exc. Cervical, Hernia procedures, Colon cancer, Pacemaker/defibrillator, Dialysis, Lung cancer, Bronchiolitis and RSV pneumonia, ADHD, Oppositional defiant disorder

Design | Reporting only | Performance Y1

Wave 4

Design work begins on behavioral health episodes in July 2016 …

Design | Reporting Only

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Ohio's State Innovation Model (SIM) Partners

3

Redesign Medicaid behavioral health benefits

1. **Elevation** –shift Medicaid match to the state to ensure more consistent provision of Medicaid treatment services statewide
2. **Expansion** – extend Medicaid coverage to 400,000 low-income residents with behavioral health needs who previously relied on county-funded services or went untreated
3. **Modernization** – update Medicaid billing codes for behavioral health providers to align with national standards and expand Medicaid services for individuals with the most intense need
4. **Integration** – coordinate care across physical and behavioral health services by enrolling individuals with behavioral health needs in Medicaid MCOs beginning January 2018

Modernize Medicaid behavioral health benefits

Recode services

- Align billing codes to national standards, separate and reprice some services, support and require appropriate claiming for Medicare services, and clarify requirements for rendering practitioners to bill
- Provider agencies may transition to the new code set beginning January 1, 2017 and must by July 1, 2017, and rendering practitioners must be enrolled by January 1, 2017 to be paid by Medicaid

Expand services

- Expand Medicaid Rehabilitation Options (MRO) for individuals with highest intensity needs beginning January 1 and fully implemented by July 1, 2017
- Create a new Specialized Recovery Services (SRS) program beginning July 1, 2016 for adults with SPMI who have monthly income below $2,199 to meet the needs of those who currently “spend down” to qualify for Medicaid (spend down ends July 1, 2016)

3

Integrate physical and behavioral health services

Coordinate care

- Move all Medicaid behavioral health services into current Medicaid managed care plan contracts beginning January 1, 2018
- Require health plans to provide comprehensive care coordination, including coordination provided by qualified community behavioral health providers

Enhance primary care

- Adopt a patient-centered medical home care delivery model across Medicaid and commercial insurance throughout Ohio in January 2018 that specifically identifies the importance of behavioral health collaboration in primary care

Reward value in behavioral health episodes of care

- Define and in January 2018 begin reporting provider performance on a package of behavioral health episodes of care, and link provider payment incentives to better health outcomes and cost savings

Redesign developmental disabilities services

- Last year, the Kasich Administration and Ohio legislature made the most significant investment in the history of developmental disabilities – $300 million in new dollars over two years
- Creating 3,000 new waivers to provide waiting list relief and to prevent persons on the waiting list from being forced to live in an institution (directly addresses the DRO lawsuit)
- Working to encourage large institutions to get smaller, in a responsible way that doesn't disrupt people's lives or jeopardize their health and safety
- Strengthening employment services so that Ohioans with disabilities that want jobs have the opportunity to work

Simplify disability determination

- Replace Ohio's two disability determination systems with one for SSI recipients – two-thirds of the Medicaid ABD population
- Ohio will increase the monthly income limit to qualify for Medicaid ABD from $634 (≈64% FPL) to $743 (75% FPL) in July 2016 (the definition of disability and all other income limits stay the same)
- Ohio Medicaid will convert all current Medicaid ABD beneficiaries from CRIS-E to *Ohio Benefits* in July 2016, including anyone who qualified by "spending down" in any of the previous 12 months
- Ohio Medicaid will waive Medicaid ABD eligibility renewals for six months (pending CMS approval) so the new eligibility criteria will not apply to current beneficiaries until eligibility renewals in 2017
- The new eligibility criteria will apply to anyone seeking Medicaid ABD for the first time beginning in July 2016

Simplify disability determination

- Ohio Medicaid will eliminate spend down in July 2016
- Anyone who previously could have qualified for Medicaid month-to-month by spending down will instead have access to more stable sources of annual health insurance coverage
- Most will be automatically enrolled in full Medicaid without spend down, including individuals who receive SSI, actually spent down in the previous year, or are eligible under the Medicaid expansion
  - Some will need to enroll in Specialized Recovery Services or establish a Qualified Income Trust to retain Medicaid – anyone in this situation will be contacted and assisted to enroll in SRS or establish a QIT by June 30, although Medicaid eligibility is not impacted until their next eligibility renewal in 2017
- Some will no longer qualify for Medicaid because their income is too high but they qualify for Medicare, in some cases with premium assistance, or federally subsidized private insurance on the Exchange

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