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Transforming Payment for a Healthier Ohio

Governor Kasich's Advisory Council on Health Care Payment Innovation

October 18, 2013

www.HealthTransformation.Ohio.gov

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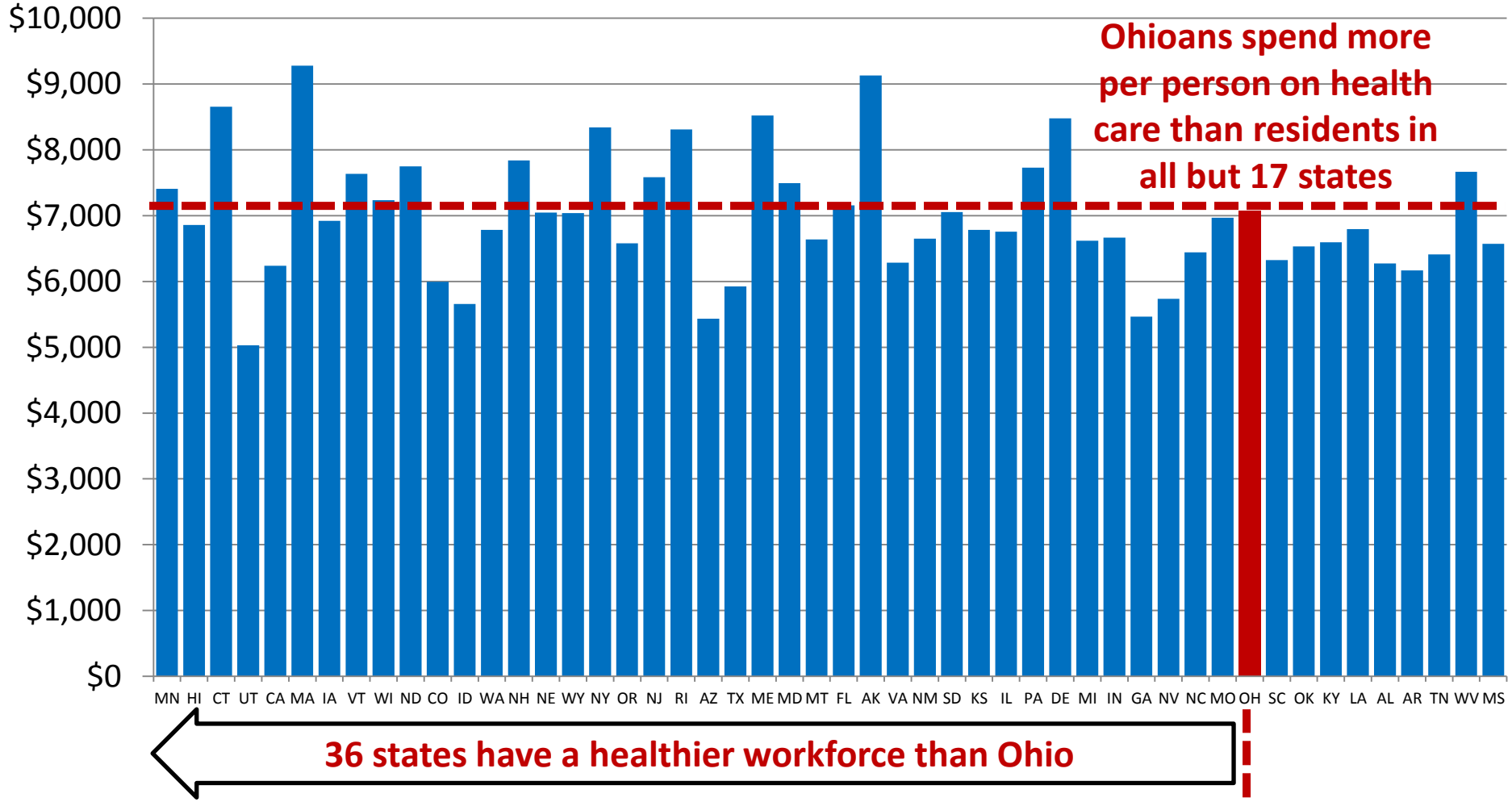
Agenda

1. **Update progress since the first meeting**
2. Share Ohio's latest thinking on payment model design
3. Review the Patient-Centered Medical Home Model
4. Review the Episode-Based Payment Model
5. Discuss next steps

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).

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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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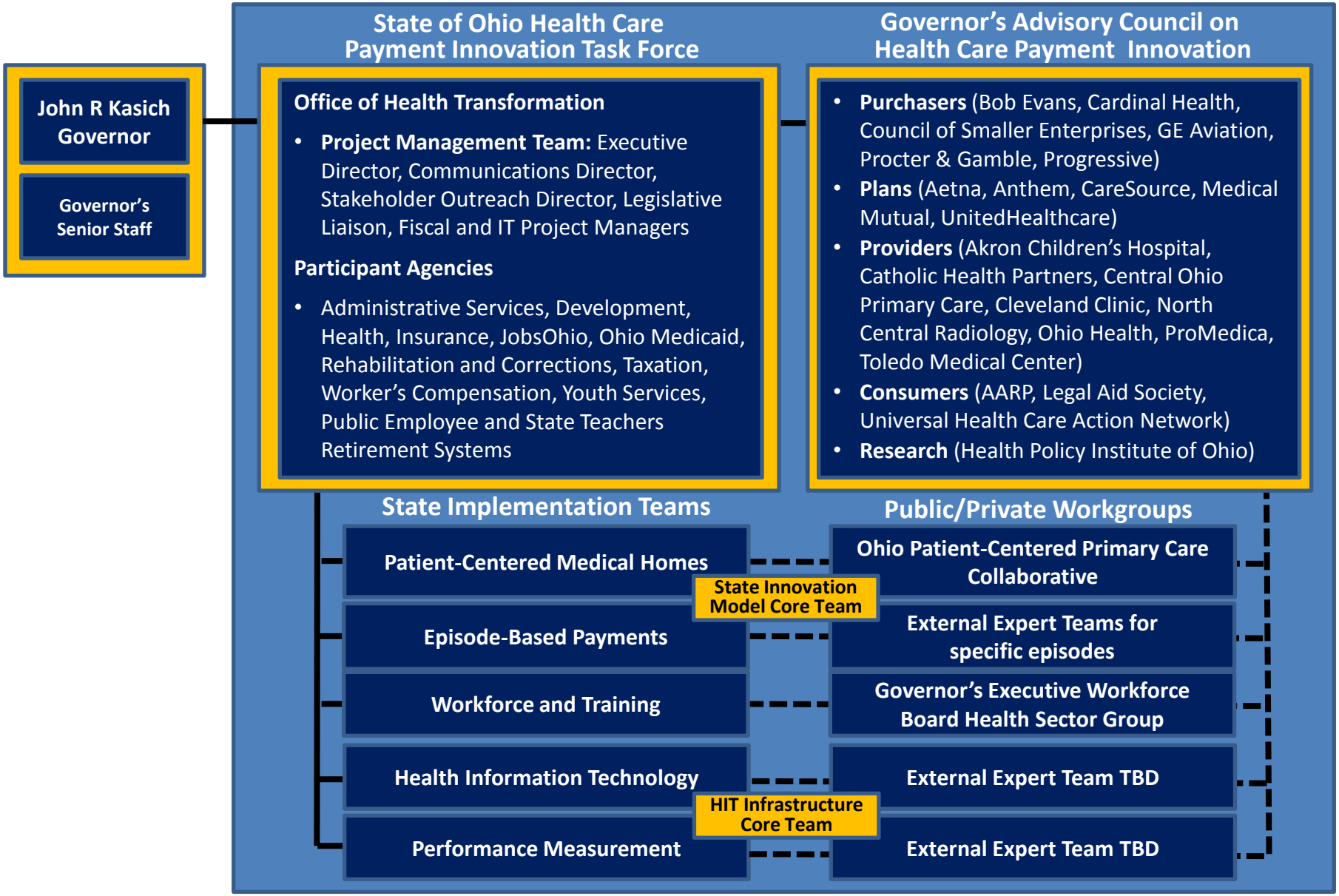
Payment Innovation Partners



State Innovation Model Grants

- Federal funding for states to design and test comprehensive State Health Care Innovation Plans. Innovation plans must:
  - Be Governor-led and multi-payer
  - Improve health, improve health care, and reduce costs
  - Incorporate a broad range of stakeholder input
- Significant funding pool
  - 16 design grants of $1-3 million each
  - 6 testing grants of $20-60 million each and Medicare participates
  - Ohio received a $3 million design grant ($4.1 million in kind) and will apply for a second round of testing grants early in 2014

SOURCE: www.innovation.cms.gov/initiatives/state-innovations

Ohio's SIM Grant Activities

- Governor's Office of Health Transformation convened experts to provide detailed input on State Innovation Model (SIM) design
  - 100+ experts from 40+ organizations deeply engaged
  - 50+ multi-stakeholder meetings to align across payers and providers
  - Top 5 payers aligned on overall strategy
- Ohio selected McKinsey & Company to assist in producing:
  - State of Ohio Healthcare Diagnostic Report
  - PCMH and Episode "Charters" to align payer decisions
  - Analytics and implementation plans to support the models
  - Ohio's Healthcare Innovation Plan (to submit October 30, 2013)

SOURCE: www.healthtransformation.ohio.gov

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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

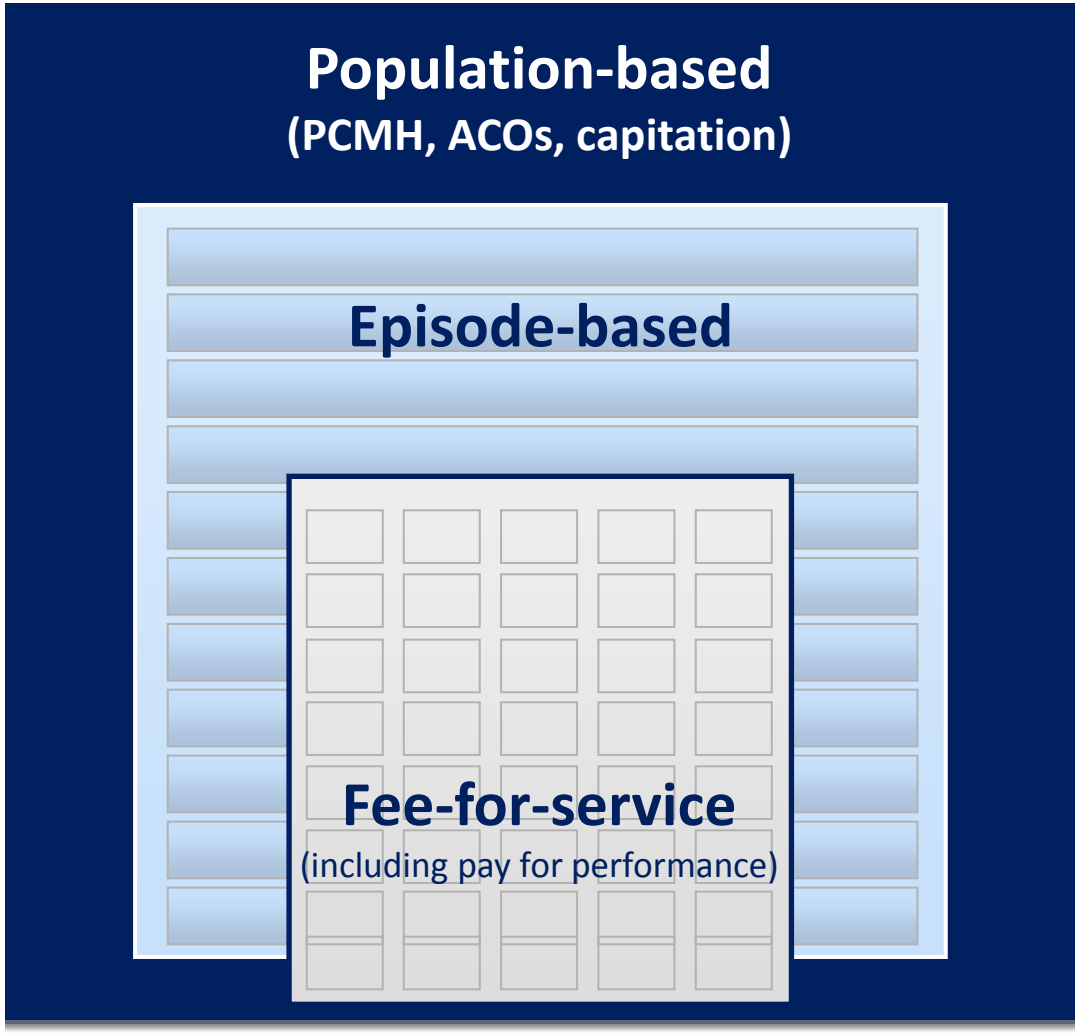
State's Role

- 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

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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Agree on degrees of standardization within each model

"Standardize approach"

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"

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

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

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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

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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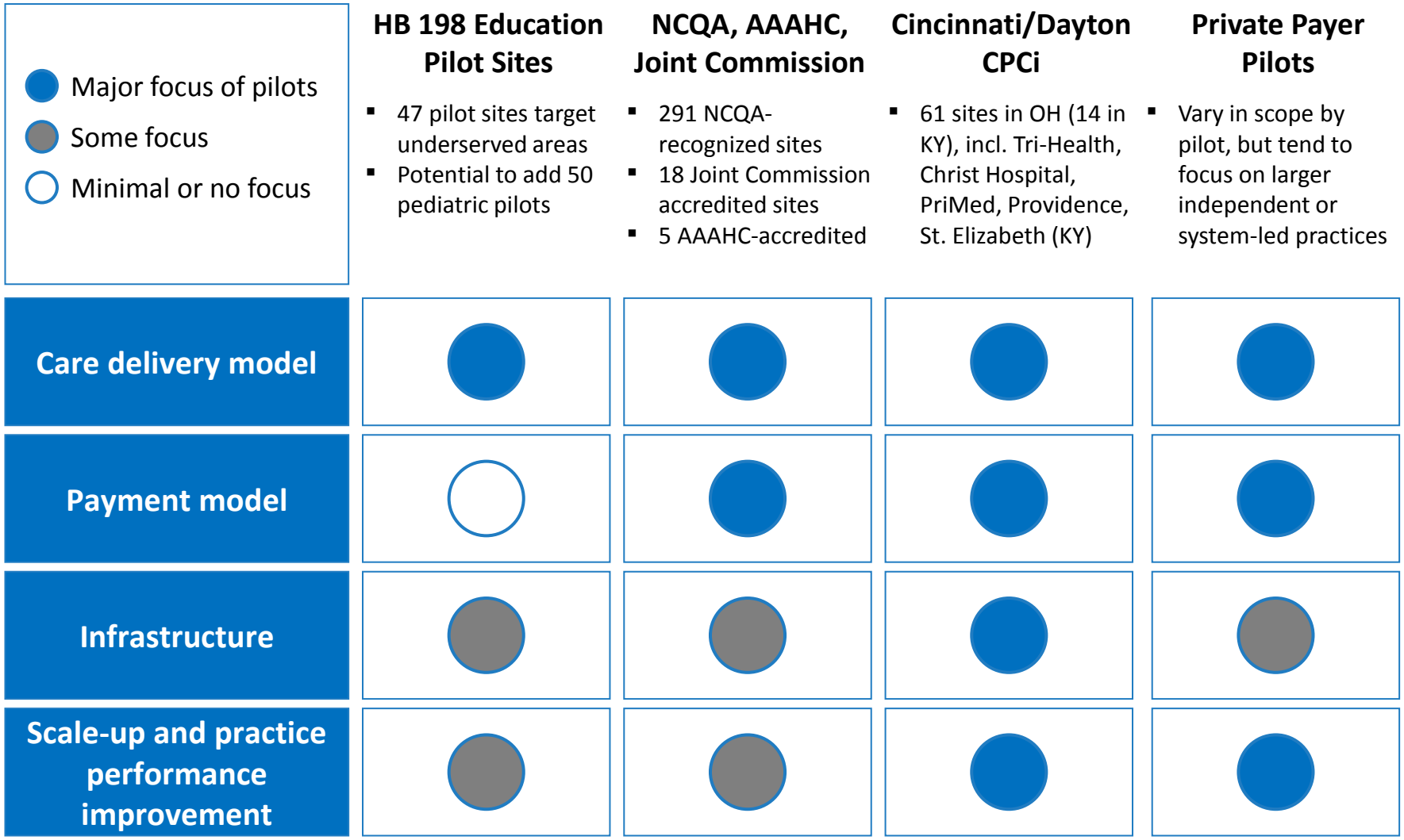
Ohio already has various PCMH projects underway



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

Comprehensive Primary Care (CPC) Initiative

- Ohio is one of only seven CPC sites nationally
- Multi-payer: Medicare, Medicaid, nine commercial insurance plans
- Bonus payments to primary care doctors who better coordinate care
- 75 primary care practices (261 providers) serving 44,500 Medicare enrollees in 4 Kentucky and 14 Ohio counties (Dayton to Cincinnati)
- 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 Health Collaborative

GREATER CINCINNATI HEALTH COUNCIL
Creating connections. Improving care.

HealthBridge
Better information. Better care. Better outcomes.

CPC Year One Milestones

CPC builds on years of effort

- Agreement on quality measures
- Agreement on a payment model
- Annual Budget
- Care Management of High-Risk Patients
- 24/7 patient access guided by the medical record
- Assess and improve patient experience of care
- Use date to guide improvement
- Care coordination across the medical neighborhood
- Improve patients shared decision-making
- Participate in market based learning collaborative
- Meaningful Use Stage 1

- 21 NQF endorsed measures
- Track one utilization and one quality metric in 2013
- Report on all to CMS in 2014

Fee-for-Service
+ Per Member Per Month
+ Shared Savings
Total Reimbursement

the Health Collaborative

CPC Enabling Infrastructure

Practices

- Electronic Health Record
- Meaningful Use
- Critical mass
- Health Information Exchanges
- Measurement of care delivery feedback loop
- Standardization of processes across payers
- Convening support

Payers

- Measurement of value (clinical outcomes and cost savings)
- Attribution methodology
- Risk adjustment methodology
- Data aggregation
- Outcome targets

the Health Collaborative

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

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Episode-Based Payment Model Design Team

Providers

- 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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Elements of an Episode-Based Payment Strategy

Program-level design decisions

Participation	Provider participation Payer participation *(Related to 'scale-up' plan for episodes)*
Account-ability	Providers at risk – Number Providers at risk – Type of provider(s) Providers at risk – Unique providers Cost normalization approach
Payment model mechanics	Prospective or retrospective model Risk-sharing agreement – types of incentives Approach to small case volume Role of quality metrics Provider stop-loss Absolute vs. relative performance rewards
Performance management	Absolute performance rewards – Gain sharing limit Approach to risk adjustment Exclusions
Payment model timing	Preparatory/"reporting-only" period Length of "performance" period Synchronization of performance periods
Payment model thresholds	Approach to thresholds How thresholds change over time Specific threshold levels Degree of gain / risk sharing Cost outliers

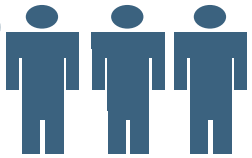
Episode-specific design decisions

Core Episode definition	Quarterback selection Triggers Episode timeframe – Type/length of pre-procedure/ event window Claims in- or excluded: pre-procedure/event window Claims in- or excluded: during procedure/event Claims in- or excluded: post procedure/event (incl. readmission policy)
Episode cost adjustment	Risk adjustors Unit cost normalization - Inpatient Unit cost normalization - Other Adjustments for provider access Approach to cost-based providers Clinical exclusions
Quality metric selection	Approach to non-claims-based quality metrics Quality metric sampling Quality metrics linked to payment Quality metrics for reporting only

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

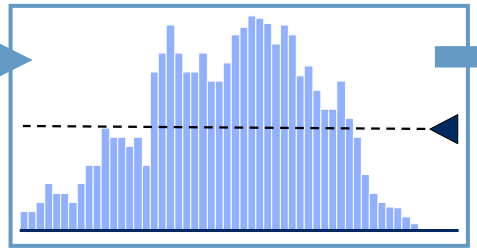
Payers reimburse for all services as they do today

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]



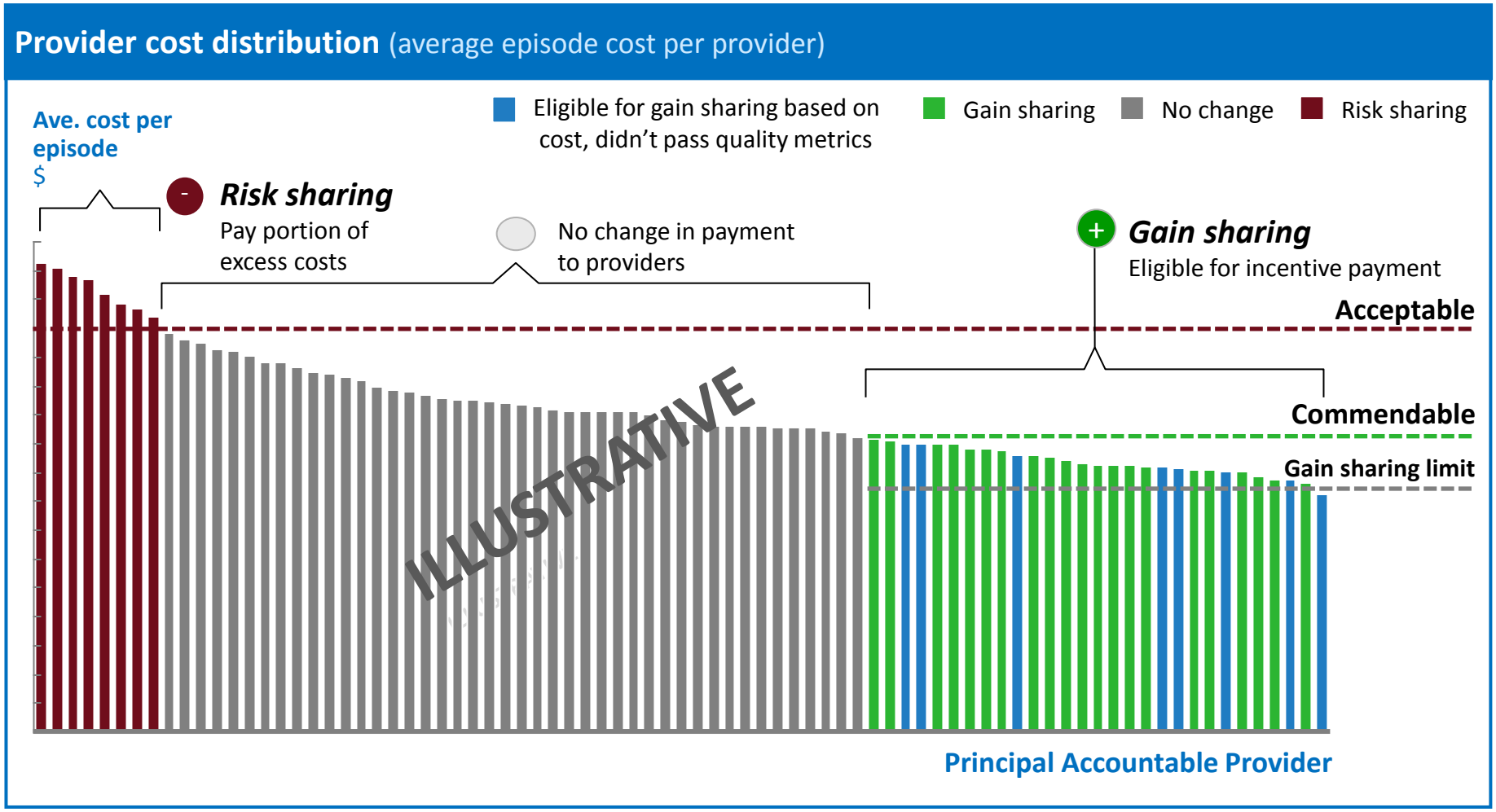
Compare average costs to predetermined ''commendable' and 'acceptable' levels[2]

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

Episode Algorithm Design Elements

*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

* Algorithm currently in use by the Arkansas Payment Improvement Initiative

Up to 70% of spend may be addressed 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	

NOTE: National data

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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What this all means for Ohio's stakeholders

Patients	▪ Experience a more person-centered approach to healthcare, receiving support to coordinate care across all providers ▪ Increasingly receive more emphasis on health, wellness, and health system accountability once a health issue arises
Providers	▪ Continue to deliver care to patients and submit fee-for-service claims (unless they have contracted an alternative model with individual payers) ▪ Experience a more consistent payment methodology; reinforcing shift to value-based care ▪ May receive additional incentives based on delivery of high quality, efficient care ▪ May receive funds to support care coordination activities or practice transformation
Purchasers	▪ Continue to work with payers to gain health care coverage for employees and families ▪ Where they manage their own risk pools, will share benefits with providers, who are increasingly incentivized and able to provide more value-based care ▪ Will over time see additional benefit in healthier workforce
Payers	▪ Continue to contract with providers and purchasers on an individual basis, and create and deliver products for customers ▪ Run additional analytics to evaluate, incent, and support providers' value-based care ▪ Where they manage risk pools directly, will share benefits with providers

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Next Steps

1. Convene clinical workgroups to create Ohio specific technical definitions for five episodes (next 3 months)
2. Continue CPCi efforts in SW Ohio (ongoing)
3. Submit a State Healthcare Innovation Plan to CMMI (by October 30, 2013)
4. Apply for a federal SIM Testing Award (early 2014)

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