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Innovations on the Home Front

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2011 Ohio Crisis

- $8 billion state budget shortfall
- 89-cents in the rainy day fund
- Nearly dead last in job creation (2007-2009)
- Medicaid spending increased 9% annually (2009-2011)
- Medicaid over-spending required multiple budget corrections
- Ohio Medicaid stuck in the past and in need of reform
- More than 1.5 million uninsured Ohioans (75% of them working)

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

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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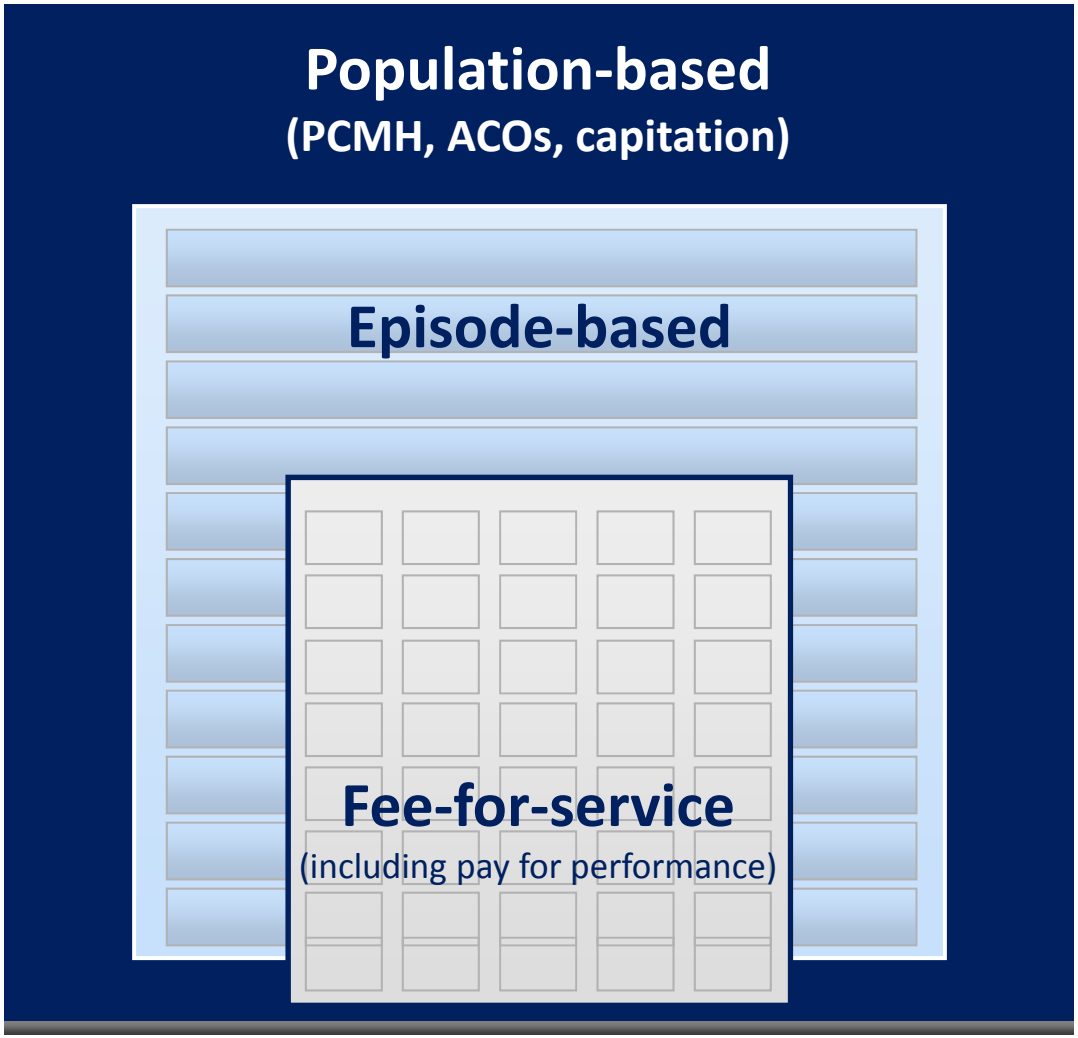
Shift to population-based and episode-based payment

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

CareSource

MOLINA HEALTHCARE

Buckeye Community Health Plan

PARAMOUNT ADVANTAGE

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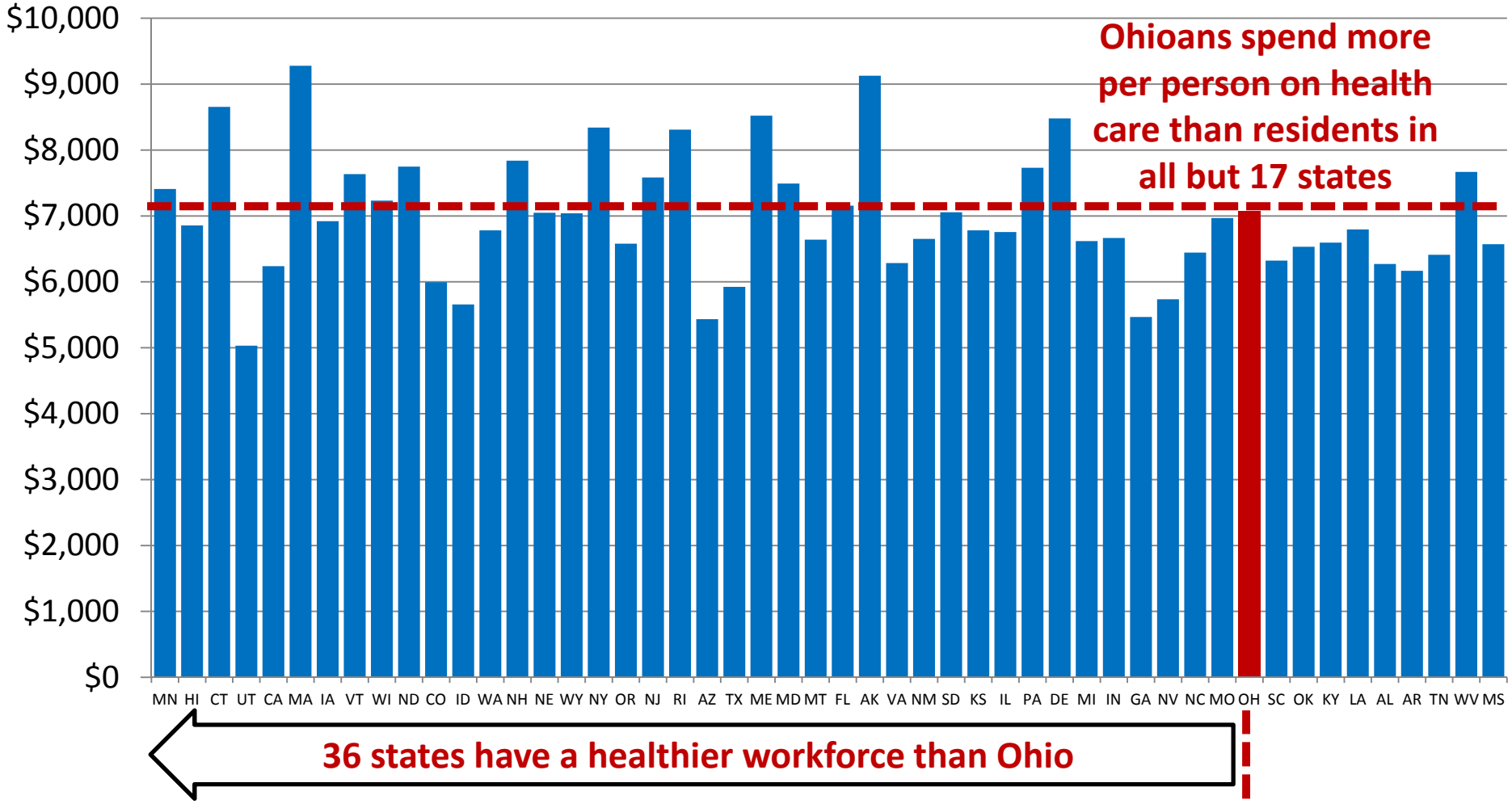
Health Care Spending per Capita by State (2011) in order of resident health outcomes (2009)



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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).

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Additional Information

1. Overview of the Patient-Centered Medical Home Model
2. Overview of the Episode-Based Payment Model

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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

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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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

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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

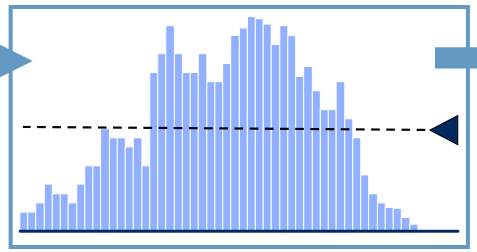
Payers reimburse for all services as they do today

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]



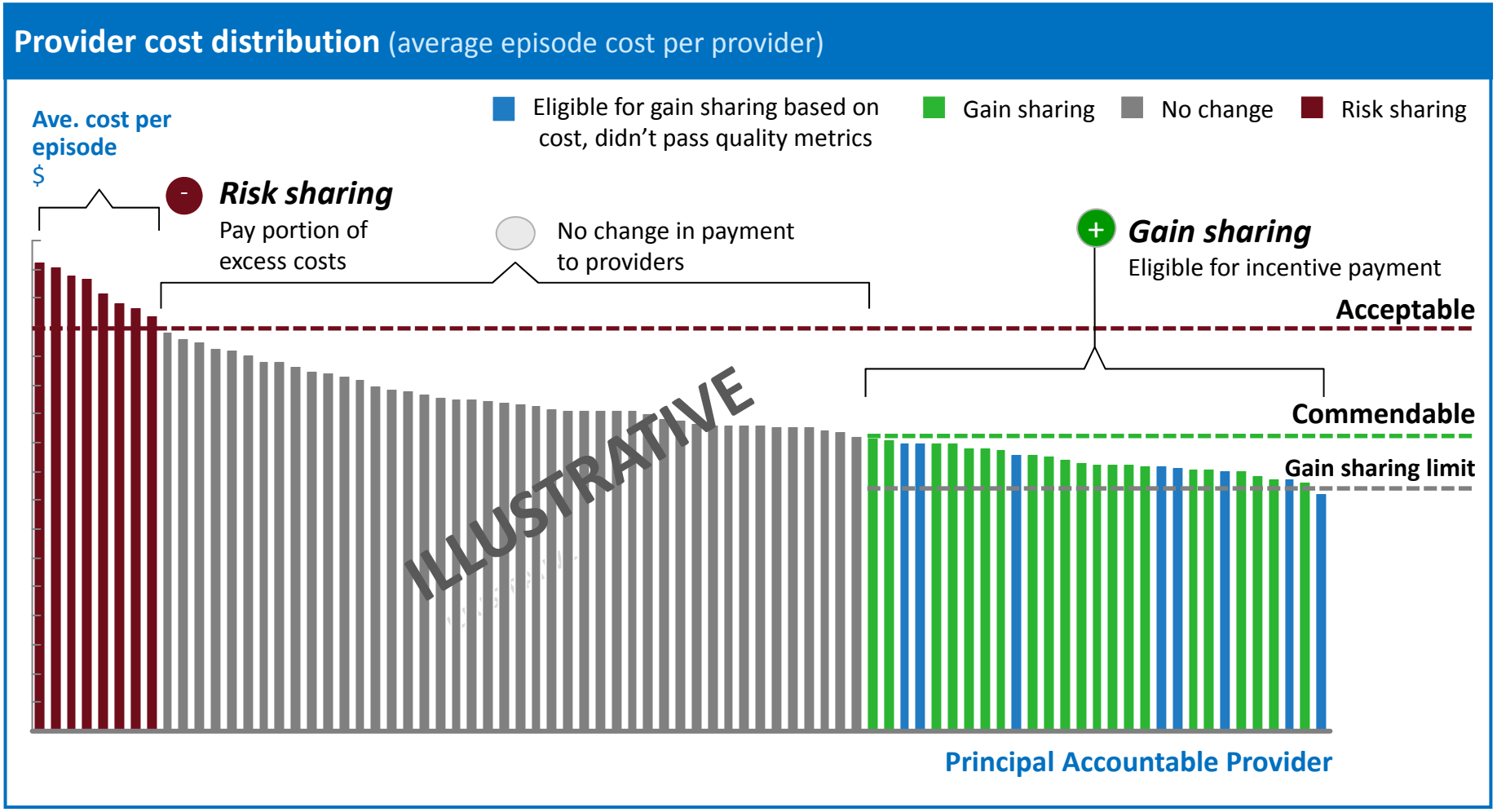
Compare average costs to predetermined ''commendable' and 'acceptable' levels[2]

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

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)

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

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 January 10, 2014.