IOM Roundtable on Population Health Improvement Workshop:

Health Care and Public Health – Opportunities at the Interface

Keck Center of the National Academies
Washington DC

February 5, 2015

Case Study 1: Payment Reform and How the Public Health and Health Care Relationship Advances It

- Moderator - Sarah Linde , HRSA
- Panel - Mary Applegate, Medical Director – Ohio Medicaid
  - Ted Wymyslo, CMO – Ohio Association of Community Health Centers, former Director Ohio Department of Health

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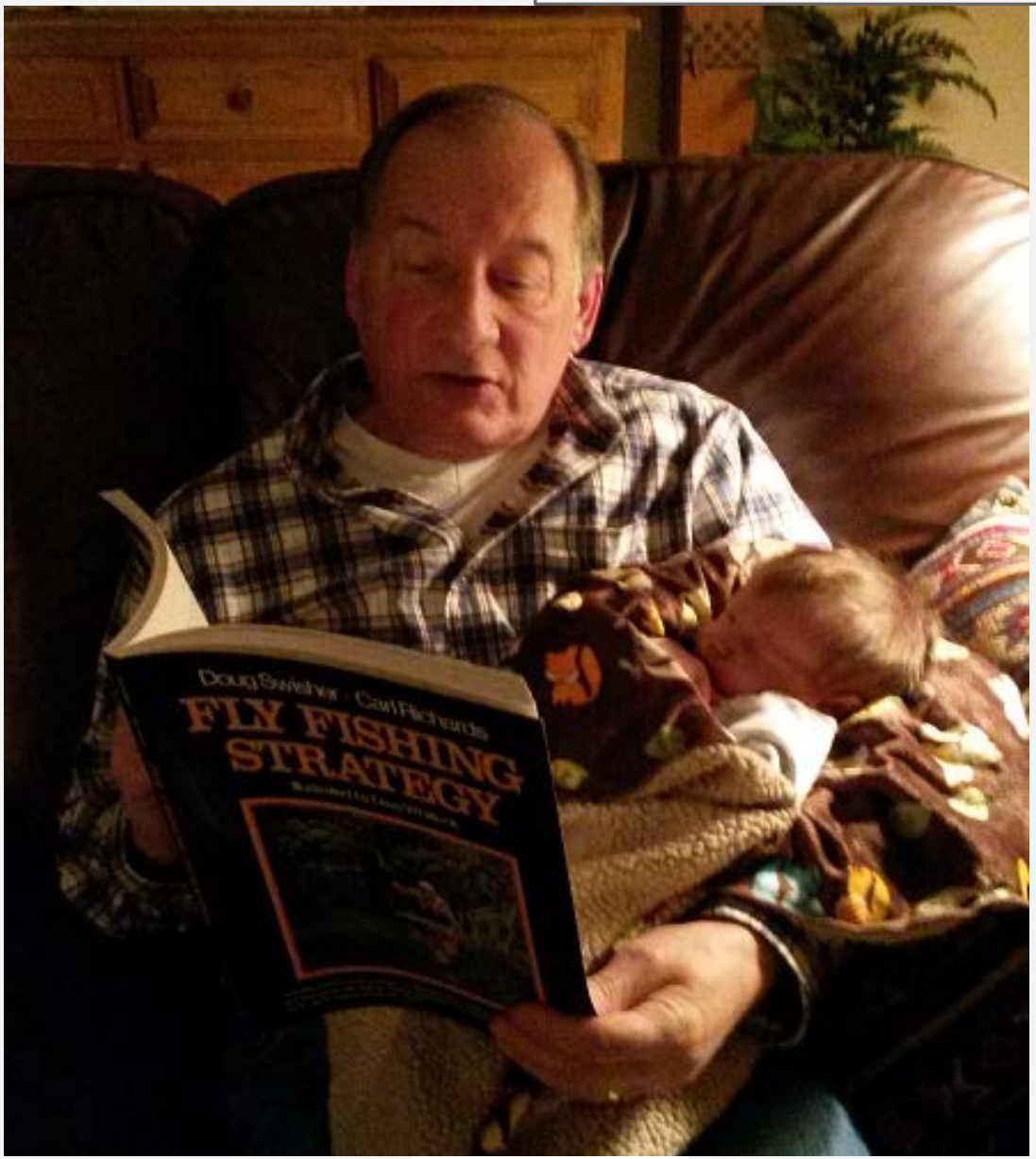
mommy's
little
roar!


FLY FISHING
STRATEGY

Transformation of Healthcare in Ohio

Regional Collaboratives – Cinci, Cols, Cleve	
Office of Health Transformation(OHT)	1/11
Ohio Department of Health – PCMH directive	2/11
OHT Innovation Framework	7/11
Ohio Patient-Centered Primary Care Collaborative	11/11
IOM Report – Integration of PH/PC	3/12

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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

- Coordinates communication among existing Ohio PCMH practices
- Facilitates statewide learning in collaborative PCMH practices in Ohio
- Facilitates new PCMH practice startup in Ohio
- Shapes policy in Ohio for statewide PCMH adoption

Facilitated by the Ohio Department of Health

Priorities for Improved Health

Transformation of Healthcare in Ohio

Ohio PCMH Education Pilot Project - startup	**7/11**
CMMI- Comprehensive Primary Care Initiative	**11/11**
Governor's Advisory Council on Healthcare Payment Reform	**1/13**
CMMI State Innovation Model (SIM) Planning Grant	**2/13**
Medicaid Extension in Ohio	**1/14**
CMMI SIM Testing Grant	**12/14**

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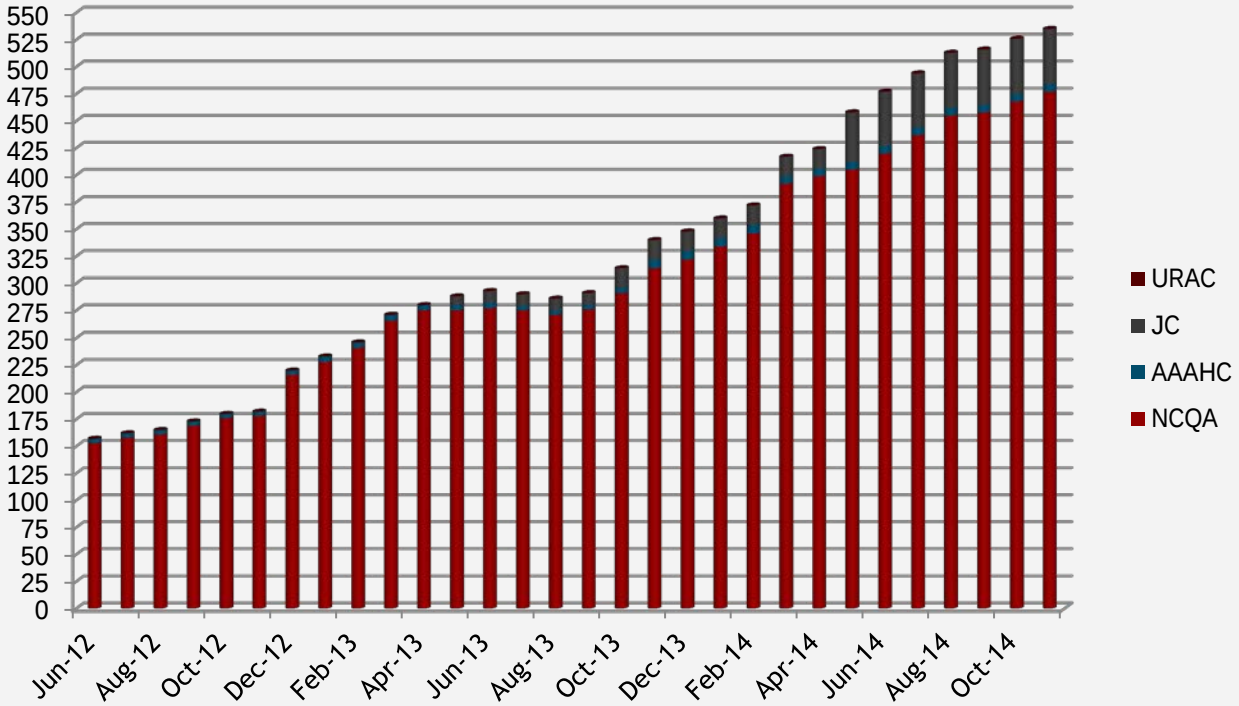
Ohio PCMH Recognized Sites November, 2014



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If you want to build a ship, don't drum up people to collect wood and don't assign them tasks and work, but rather teach them to long for the endless immensity of the sea.

-Antoine de Saint-Exupery

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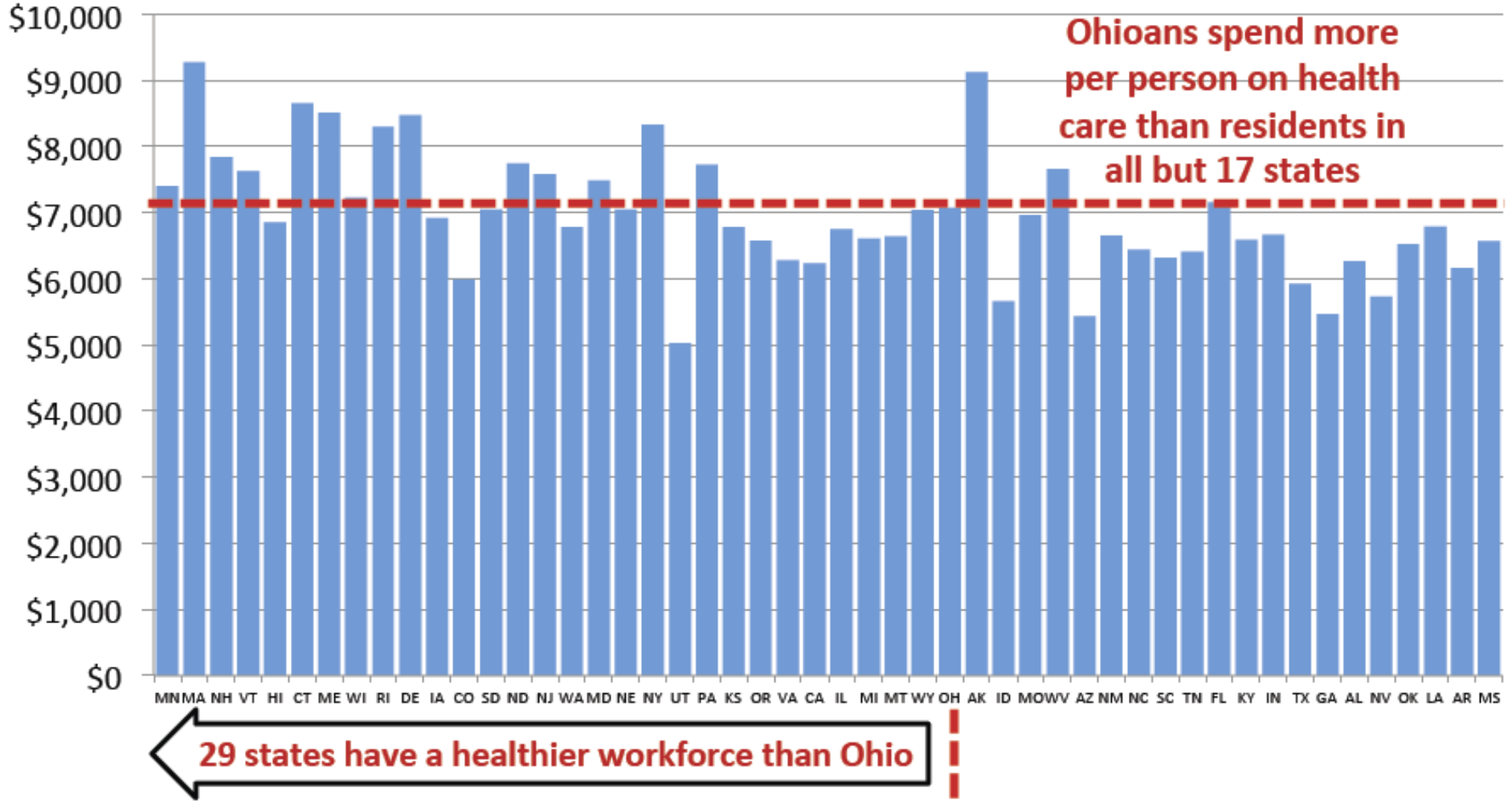
Prescription for Population Health: **Working Together** to Make A Difference

We
Align
Design
Develop
Implement a PLAN
Focused on a population
With specific measurement targets
Based on sound evidence of best clinical practice
In the context of public health and sociopolitical systems
Then figure out how to sustain through value-based purchasing

Health Care Spending per Capita by State (2011) in order of resident health outcomes (2014)



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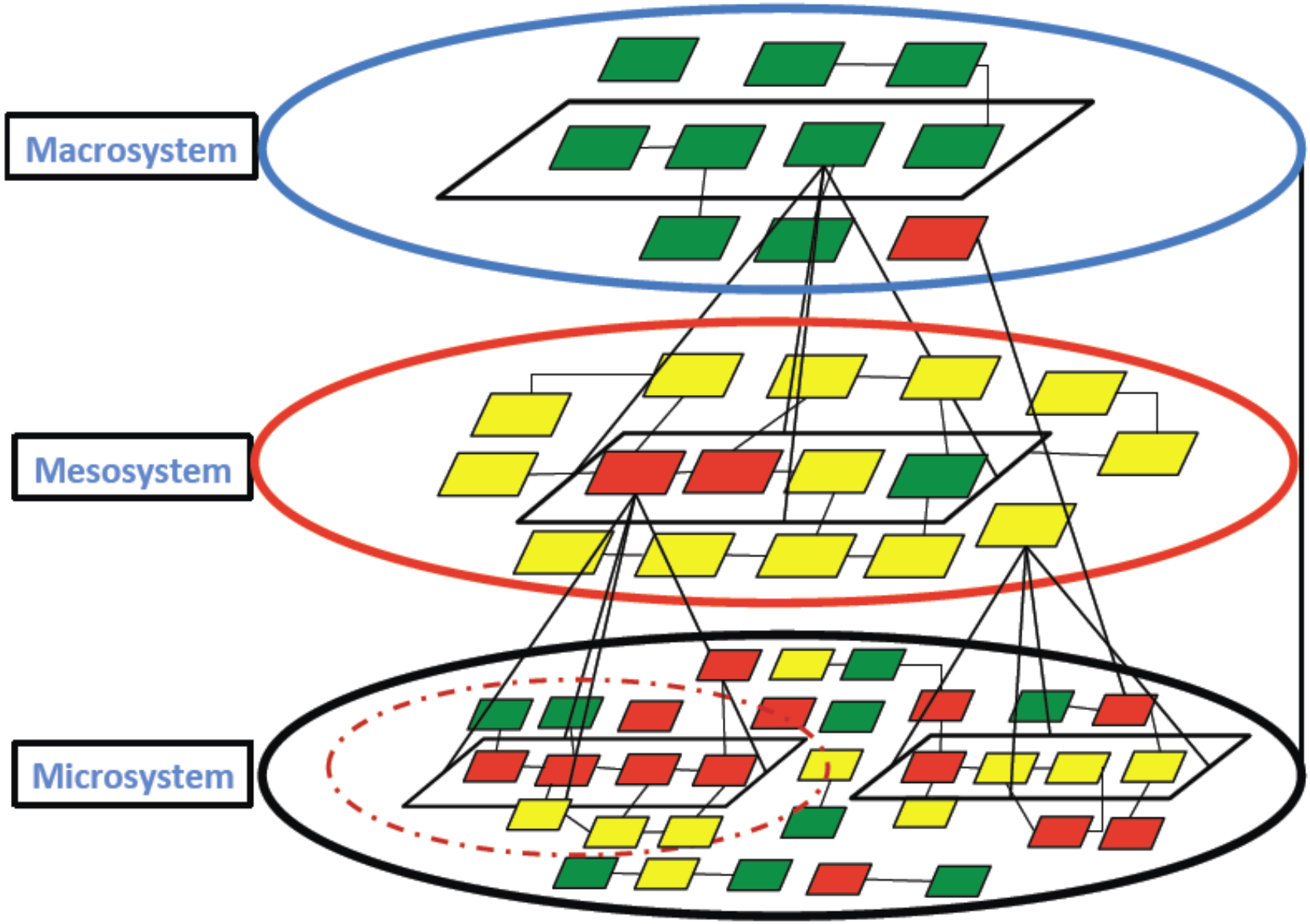
Sources: CMS *Health Expenditures by State of Residence* (2011); The Commonwealth Fund, *Aiming Higher: Results from a State Scorecard on Health System Performance* (May 2014).

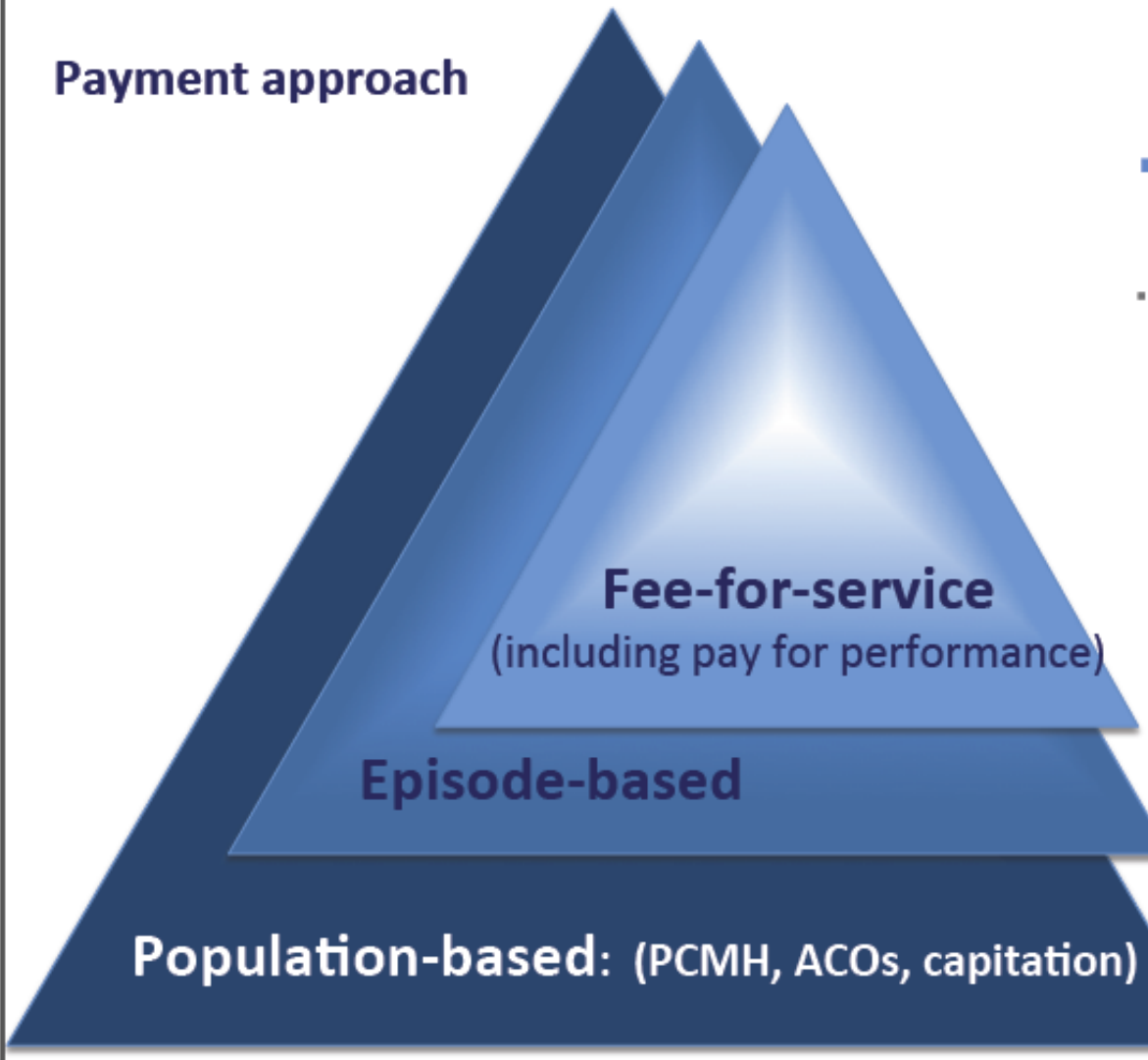
Microsystems are the building blocks that come together to form Macro-organizations



Illustrative Reliability Mapping Mock-up

Reliability Defect Rate	Level Estimat
10^3 1 in 1000	Three
10^2 1 in 100	Two
10^1 1 in 10	One

Shift to population- and episode-based payment



Most applicable for

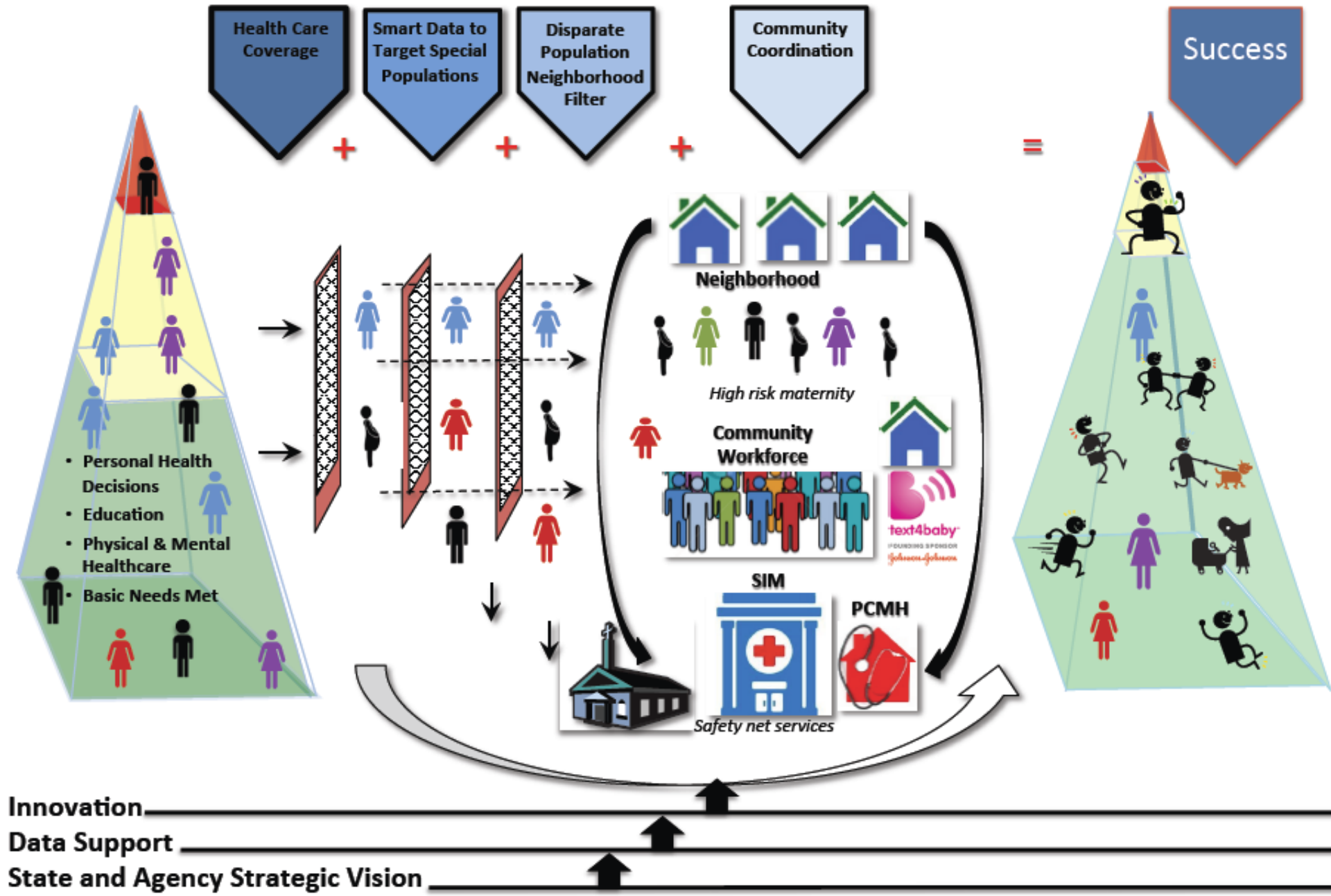
- Discrete services correlated with favorable outcomes or lower cost

- Acute procedures (e.g., CABG, hips, stent)
- Most inpatient stays including post-acute care, readmissions
- Acute outpatient care (e.g., broken arm)

- Primary prevention for healthy population
- Care for chronically ill (e.g., managing obesity, CHF)

Creating Systems to Improve Health Outcomes

Ohio Department of Medicaid



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CURRENT INITIATIVES | BUDGETS | NEWSROOM | CONTACT | VIDEO

Ohio's State Innovation Model (SIM) Test Grant Application:

- Population Health Plan
- Delivery System Plan
- Payment Models
- Regulatory Plan
- HIT Plan
- Stakeholder Engagement
- Quality Measurement

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 h
Implement episode-based payments
Coordinate health information technology infrastructu
Coordinate health sector workforce programs
Support regional payment reform initiatives
Federal Health Insurance Exchange

Payment Models:

- PCMH Charter
- Episode Charter
- Overview Presentation

- 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 Q1 2015
  - 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, etc.
- Comprehensive, complementary strategies for health sector workforce development and health information technology
- Active stakeholder participation: 150+ stakeholder experts, 50+ organizations, 60+ workshops, 20 months and counting …

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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

Elements of the episode definition

Category	Description
1 Episode trigger	▪ Diagnoses or procedures and corresponding claim types and/or care settings that characterize a potential episode
2 Episode window 3 Claims included	▪ **Pre-trigger window:** Time period prior to the trigger event; relevant care for the patient is included in the episode ▪ **Trigger window:** Duration of the potential trigger event (e.g., from date of inpatient admission to date of discharge); all care is included ▪ **Post-trigger window:** Time period following trigger event; relevant care and complications are included in the episode
4 Principal accountable provider	▪ Provider who may be in the best position to assume principal accountability in the episode based on factors such as decision making responsibilities, influence over other providers, and portion of the episode spend
5 Quality metrics	▪ Measures to evaluate quality of care delivered during a specific episode
6 Potential risk factors	▪ Patient characteristics, comorbidities, diagnoses or procedures that may potentially indicate an increased level of risk for a given patient in a specific episode
7 Episode-level exclusions	▪ Patient characteristics, comorbidities, diagnoses or procedures that may potentially indicate a type of risk that, due to its complexity, cost, or other factors, should be excluded entirely rather than adjusted

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

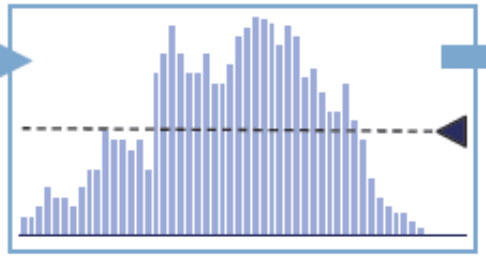
Payers reimburse for all services as they do today

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



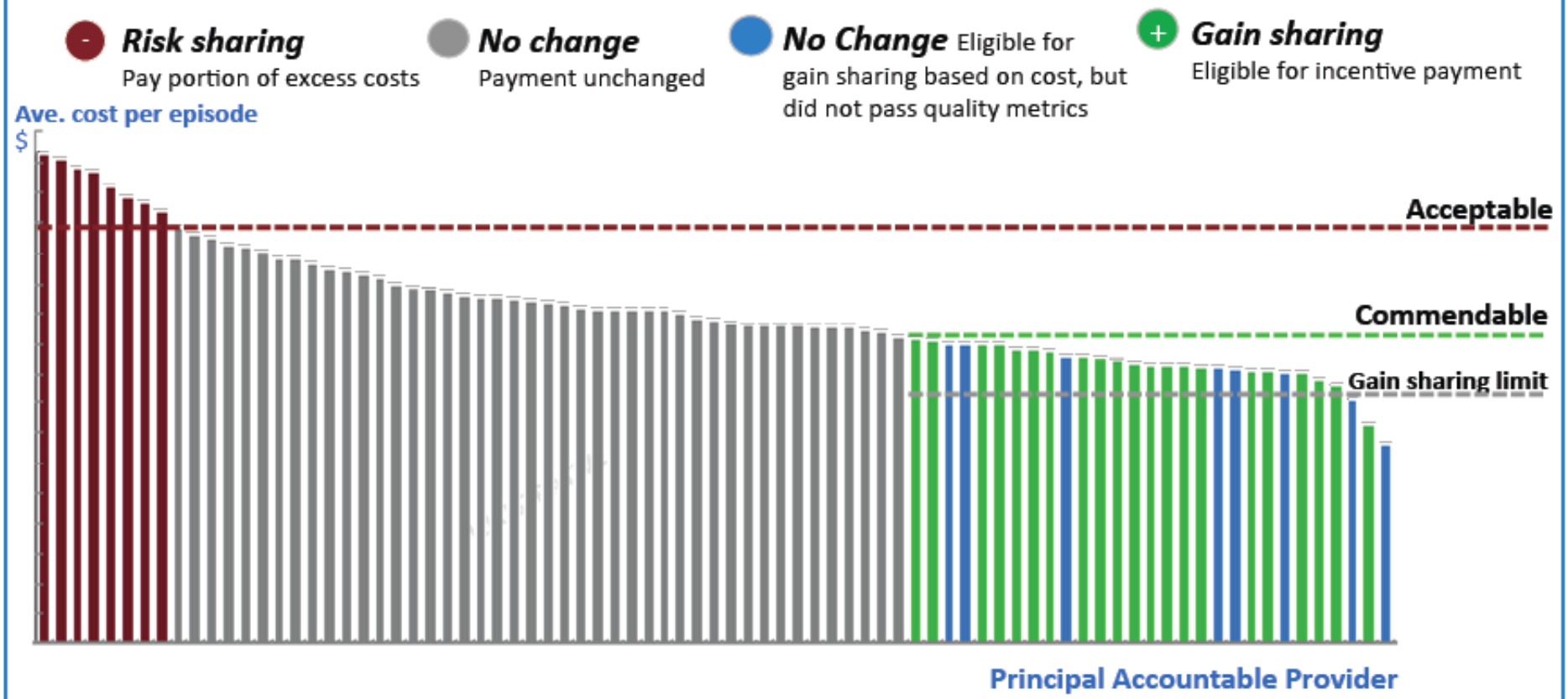
Compare average costs to predetermined "commendable" and "acceptable" levels

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

Retrospective thresholds reward cost-efficient, high-quality care

Provider cost distribution (average episode cost per provider)



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NOTE: Each vertical bar represents the average cost for a provider, sorted from highest to lowest average cost

Anthem

aetna

UnitedHealthcare

MEDICAL MUTUAL

CareSource

MOLINA HEALTHCARE

Buckeye Community Health Plan

PARAMOUNT ADVANTAGE

This is a sample report; actual reports will be released in 2015

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EPISODE of CARE PAYMENT REPORT

PERINATAL

Jul 1, 2013 to Jun 30, 2014

Reporting period covering episodes that ended between July 1, 2013 and June 30, 2014

PAYER NAME: Ohio – Medicaid FFS PROVIDER CODE: 1234567 PROVIDER NAME: XYZ Women's Health Center

You would be eligible for gain or risk sharing of N/A[1]

Episodes inclusion and exclusion

Total episodes: 154

Risk adjusted average spend per episode

Episodes risk adjustment

95% of your episodes have been risk adjusted

Quality metrics

Your performance on quality metrics that will be ultimately linked to gain sharing	
HIV screening	53%
GBS screening	71%
C-section	31%
Follow-up visit	30%

Potential gain/risk share

N/A[1]

1 Not applicable during reporting-only period

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Creating Systems to Improve Outcomes

- What can YOU do to save a baby?
- What can **we** do better together?

Mary.applegate@medicaid.ohio.gov
& public health partners

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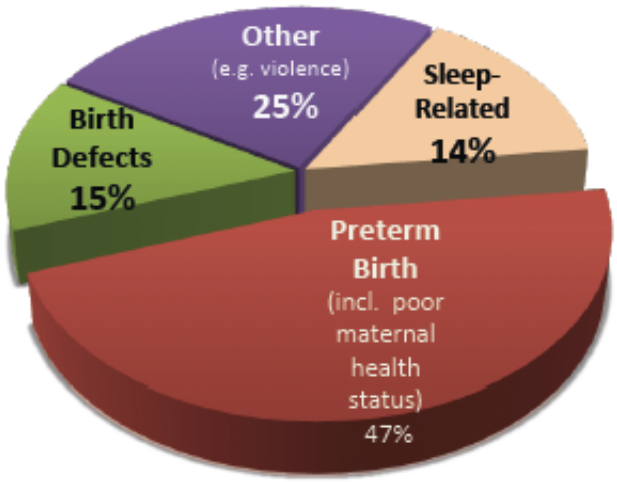
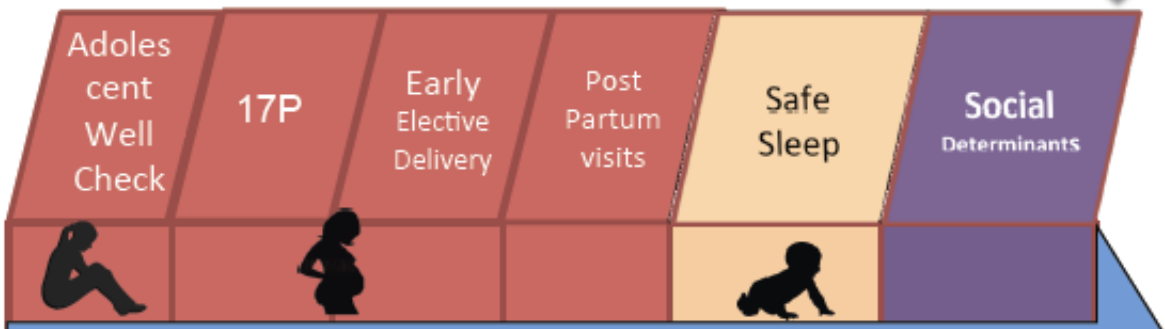
Specific VBP example: Infant Mortality



Causes of Infant Mortality

More Proximate Infant Mortality Process Measures



1. **Public Health:** Data (vital stats, geocoding) Safety net services, community coordination
2. **Medicaid:** Presumptive eligibility, Enrollment, Care Management Payment (P4P) & Innovation: Hospitals, PCMH/ACO
3. **Clinical/Health Systems:** Ohio Perinatal Quality Collaborative: Development, standardization & adherence to best practice
4. **Patients/Families:** Engagement, Outreach, Cultural interface

Other participants

- Policy makers at all levels
- Schools
- Child Care entities
- Community Organizations
- Faith-based communities
- Employers & Businesses
- Federal/grant partners
- Cultural Groups
- Lawyers/Advocates

State of Ohio Infant Mortality Plan: **Designed** to Address Disparities

Why?

Infant mortality is considered the mark of the overall health of a city, state or nation. Despite enormous efforts, Ohio lags behind other states.

2011 Infant deaths	Numbers of babies that died	Infant Mortality Rate per 1000 births
Overall	1087	7.88
White	703	6.3
African American	373	15.45

How to Bring Focus to Develop a Plan?

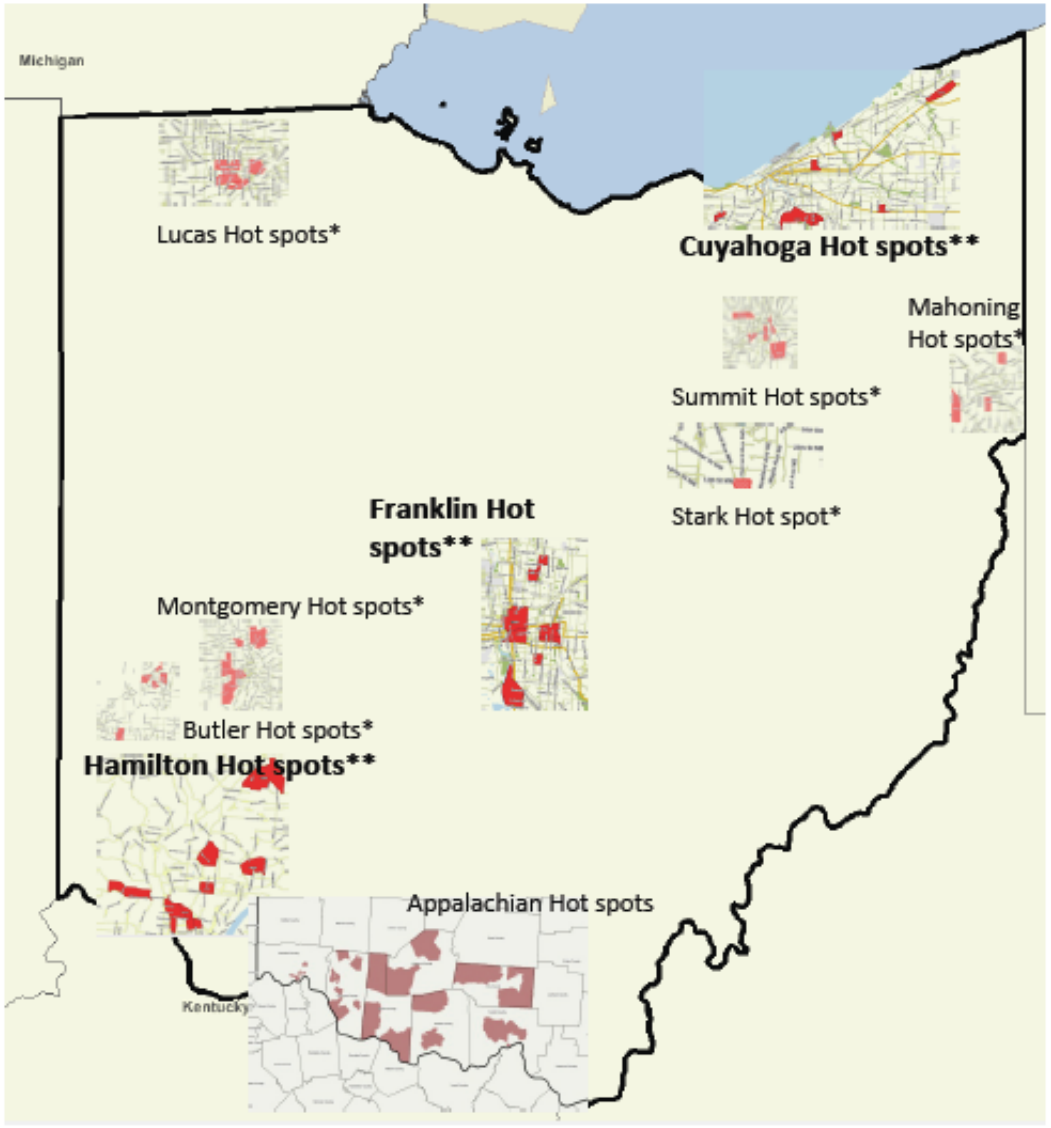
What to Measure? By diverse subpopulations

Preterm births are the single largest contributor to death rates----------	Measure: Vital stats- birth record
greatly influenced by the **declining health of Ohio's women**	
prompting the focus on	
1. **Adolescent health** (Pre-Conception population) and----------	Core Medicaid Measure, HEDIS
2. **Post Partum visits** (gateway to Inter-conception health---------	Core Medicaid Measure, HEDIS
– until "Well Woman measure established for population)	
3. **Cultural** issues	Measure the differences, Census tracts for all
Unsafe sleep environments and ----------	Hospital safe sleep audits, campaign numbers
Exposure to **tobacco products** are also important causes----------	ICD-10 claims that include tobacco use

State of Ohio Infant Mortality Plan: **Designed** to Address Disparities

Where?

Use data for strategic focus:



What to do?

1. **Target neighborhoods** with highest preterm birth & low birth weight rates
2. **Utilize Community Health Workers,** maximizing opportunities to receive enhanced maternal care through Medicaid Managed Care
3. **Invest in innovative care** models
4. **Link** hospitals & clinicians to local public health for community coordination & future sustainability
5. **Leverage** existing systems w data transparency & payment innovation