



Governor's Office of  
Health Transformation

# Health Transformation in Ohio: What's Next?

The Center for Community Solutions  
71<sup>st</sup> Annual Human Services Institute

November 6, 2013

[www.HealthTransformation.Ohio.gov](http://www.HealthTransformation.Ohio.gov)

# The Challenge

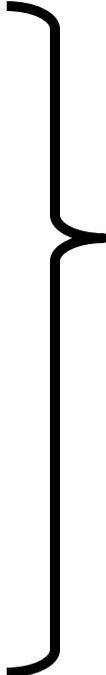
**Target Hot Spots:** A few people account for most spending

**Align Programs:** The system is fragmented, and things go wrong as a result

# The Vision

<b>Person-Centered</b>	<b>not</b>	<b>Program-Centered</b>
<b>Independence</b>	<b>not</b>	<b>Dependence</b>
<b>Prosperity</b>	<b>not</b>	<b>Poverty</b>
<b>Innovation</b>	<b>not</b>	<b>Bureaucracy</b>

# Existing Resources

<b>Health</b>	<b>\$22.2B</b>		<b>Programs for Children = \$18B</b>
<b>Education</b>	<b>\$13.9B</b>		
<b>Workforce</b>	<b>\$2.0B</b>		
<b>Other Social Services</b>	<b>\$6.0B</b>		

Notes: Includes federal and state funding, not local; Health Care includes Medicaid, BWC, DRC, DAS and PERS; Education includes ODE and Regents; Workforce includes Supplemental Security Income, not Unemployment Compensation; Other Social Services includes JFS non-workforce plus Supplemental Nutrition Assistance Program benefits.

# Transformation Priorities

## Health

*Continue to modernize Medicaid and improve overall health system performance*

## Education

*Coordinate programs that support the best possible start for Ohio's children*

## Workforce

*Create a unified workforce system that supports business in meeting its workforce needs*

## Shared Services

*Share services within and beyond boundaries to improve program efficiency*



**Target  
Hot Spots  
and Align  
Programs**

# Ohio Health and Human Services Transformation Plan

Modernize Medicaid	Streamline Health and Human Services	Pay for Value
<b><i>Initiate in 2011</i></b>	<b><i>Initiate in 2012</i></b>	<b><i>Initiate in 2013</i></b>
<i>Advance the Governor Kasich's Medicaid modernization and cost containment priorities</i>	<i>Share services to increase efficiency, right-size state and local service capacity, and streamline governance</i>	<i>Engage private sector partners to set clear expectations for better health, better care and cost savings through improvement</i>
<ul style="list-style-type: none"> <li>• Extend Medicaid coverage to more low-income Ohioans</li> <li>• Eliminate fraud and abuse</li> <li>• Prioritize home and community services</li> <li>• Reform nursing facility payment</li> <li>• Enhance community DD services</li> <li>• Integrate Medicare and Medicaid benefits</li> <li>• Rebuild community behavioral health system capacity</li> <li>• Create health homes for people with mental illness</li> <li>• Restructure behavioral health system financing</li> <li>• Improve Medicaid managed care plan performance</li> </ul>	<ul style="list-style-type: none"> <li>• Create the Office of Health Transformation (2011)</li> <li>• Implement a new Medicaid claims payment system (2011)</li> <li>• Create a unified Medicaid budget and accounting system (2013)</li> <li>• Create a cabinet-level Medicaid Department (July 2013)</li> <li>• Consolidate mental health and addiction services (July 2013)</li> <li>• Simplify and replace Ohio's 34-year-old eligibility system</li> <li>• Coordinate programs for children</li> <li>• Share services across local jurisdictions</li> <li>• Recommend a permanent HHS governance structure</li> </ul>	<ul style="list-style-type: none"> <li>• Participate in Catalyst for Payment Reform</li> <li>• Support regional payment reform initiatives</li> <li>• Pay for value instead of volume (State Innovation Model Grant)               <ul style="list-style-type: none"> <li>– Provide access to medical homes for most Ohioans</li> <li>– Use episode-based payments for acute events</li> <li>– Coordinate health information infrastructure</li> <li>– Coordinate health sector workforce programs</li> <li>– Report and measure system performance</li> </ul> </li> </ul>



*Governor Kasich's policy team preparing for Controlling Board, Oct. 16, 2013*



*Controlling Board testimony to extend Medicaid coverage, Oct. 21, 2013*

STATE OF OHIO CONTROLLING BOARD  
 RECORD OF BOARD ACTION WITH AT LEAST ONE NEGATIVE VOTE

ROLLING BOARD REQUEST NUMBER: Item 40, MCDO100009  
 Meeting held by the Controlling Board on 10/21/2013, the Controlling Board approved the above Board  
 Request Number as evidenced by the affirmative vote of four or more members of the Board as required by Revised Code  
 Section 127.13. The vote of each member present at the meeting is recorded below.

YES  NO CR Doyle 10/21/13 PRESIDENT OF CONTROLLING BOARD

YES  NO J. McCarroll HOUSE MEMBERS  
 CHAIR OF FINANCE COMMITTEE

YES  NO Bob Williams SENATE MEMBERS  
 CHAIR OF FINANCE COMMITTEE

YES  NO Bob Williams MAJORITY PARTY MEMBER OF THE BOARD

YES  NO Tom Sawyer MINORITY PARTY MEMBER OF THE BOARD

YES  NO [Signature] MAJORITY PARTY MEMBER OF THE BOARD

YES  NO [Signature] MINORITY PARTY MEMBER OF THE BOARD

... respectfully requests Controlling Board to provide competitive opportunity in the amount of \$1,234,567.89 for FY15, from fund 3230, ALI 501619 (Federal Choices for Victims of Domestic Violence, Columbus, Franklin County) for the Inmate Population Reformatory for Women, Marysville, Union County.

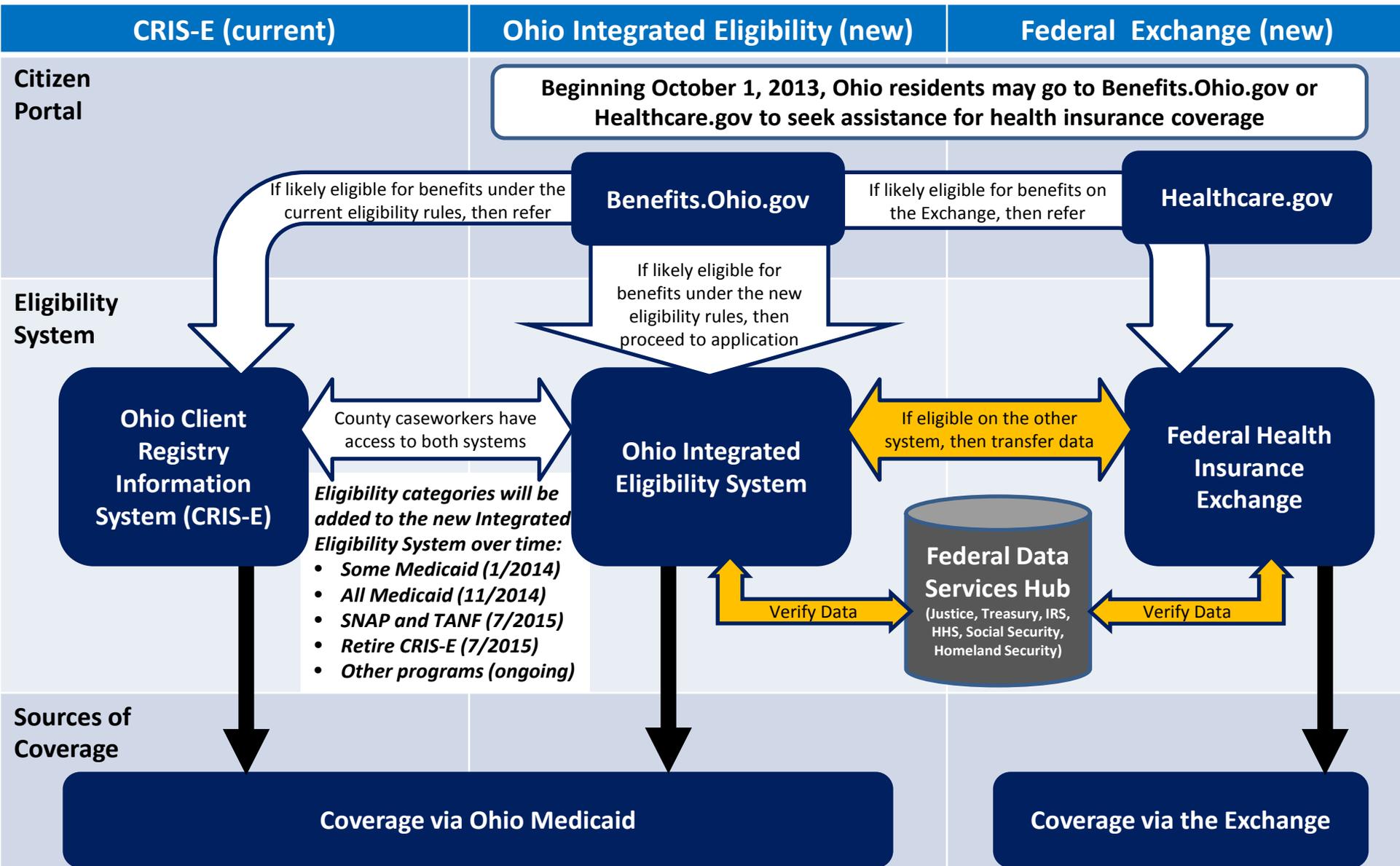
... respectfully requests Controlling Board to provide competitive opportunity in the amount of \$123,456.78 for FY15, from fund 7027, ALI 501619 (Federal Choices for Victims of Domestic Violence, Columbus, Franklin County) for the Inmate Population Reformatory for Women, Marysville, Union County.

Controlling Board approval to extend Medicaid coverage, Oct. 21, 2013

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# Ohio Resident Health Insurance Process Flow



# Ohio Health and Human Services Transformation Plan

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# Shift to population-based and episode-based payment

## Payment approach

**Population-based**  
(PCMH, ACOs, capitation)

**Episode-based**

**Fee-for-service**

(including pay for performance)

## 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



# 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

# 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:



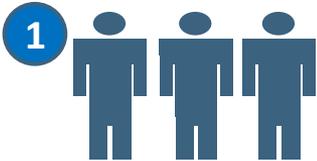
# CPC Informed Ohio's PCMH Model Design

		Standardize	Align in Principle	Differ by Design
<b>Care Delivery Model</b>	Target patients and scope		✓	
	Care delivery improvements		✓	
	Target sources of value		✓	
<b>Payment Model</b>	Technical requirements 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

# 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



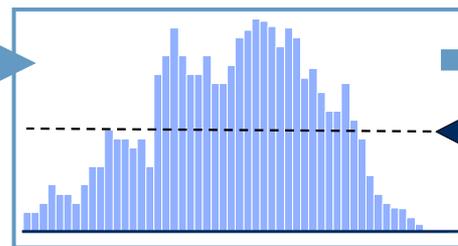
**3** **Payers** reimburse for all services as they do today

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<sup>1</sup>

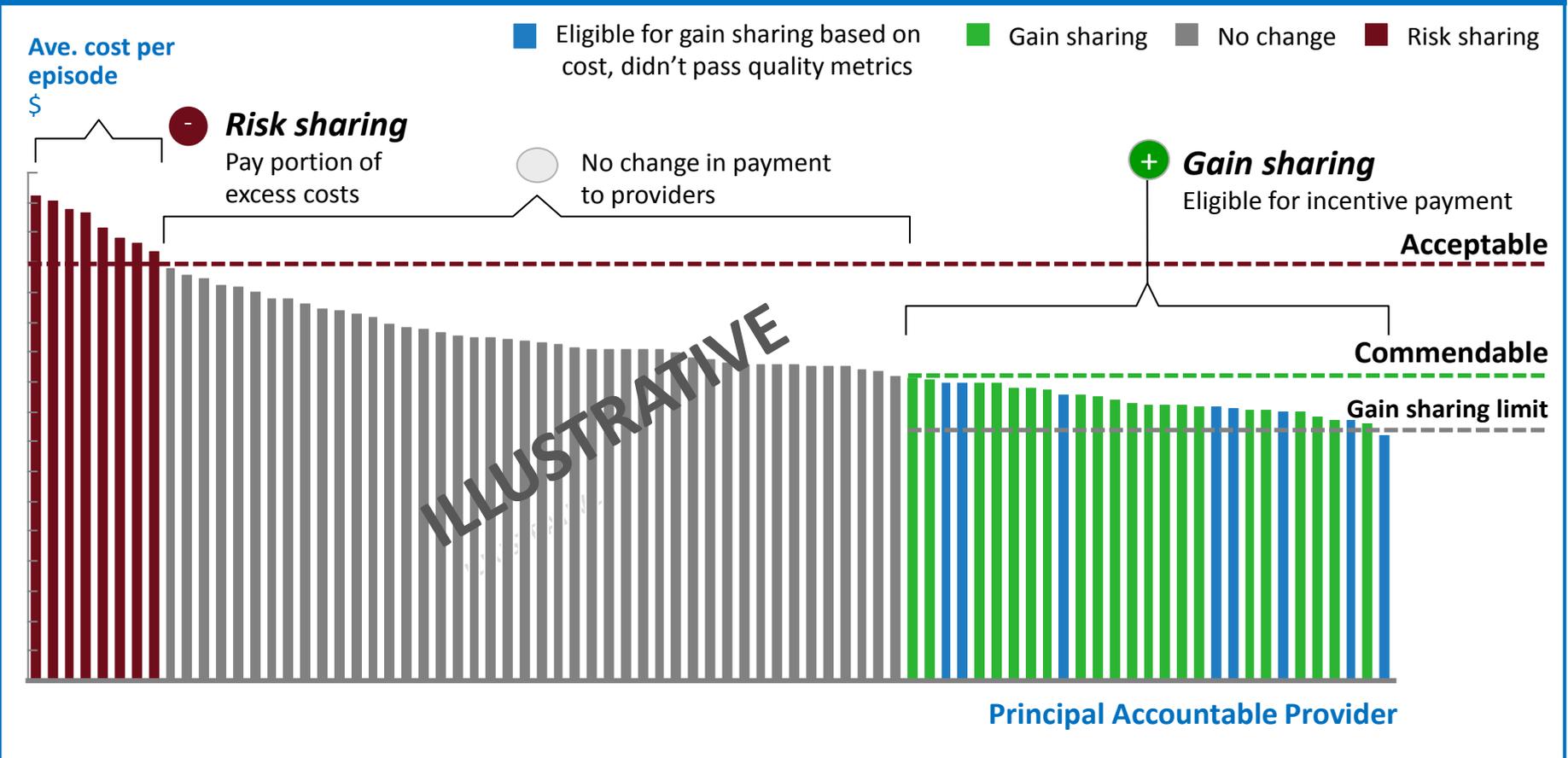


**Compare average costs** to predetermined "commendable" and "acceptable" levels<sup>2</sup>

- 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)



# 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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## 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 (online now for stakeholder review)
4. Apply for a federal SIM Testing Award (early 2014)

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CURRENT INITIATIVES

BUDGETS

NEWSROOM

CONTACT

VIDEO



### *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 homes
- Implement episode-based payments
- Coordinate health information technology infrastructure
- Coordinate health sector workforce programs
- Support regional payment reform initiatives
- Federal Health Insurance Exchange