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Patient-Centered Primary Care

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July 30, 2014

www.HealthTransformation.Ohio.gov

Agenda

1. **Health System Challenges**
2. Health System Trends in Primary Care
3. Patient-Centered Medical Home (PCMH)

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In fee-for-service, we get what we pay for

- **More volume** – to the extent fee-for-service payments exceed costs of additional services, they encourage providers to deliver more services and more expensive services
- **More fragmentation** – paying separate fees for each individual service to different providers perpetuates uncoordinated care
- **More variation** – separate fees also accommodate wide variation in treatment patterns for patients with the same condition – variations that are not evidence-based
- **No assurance of quality** – fees are typically the same regardless of the quality of care, and in some cases (e.g., avoidable hospital readmissions) total payments are greater for lower-quality care

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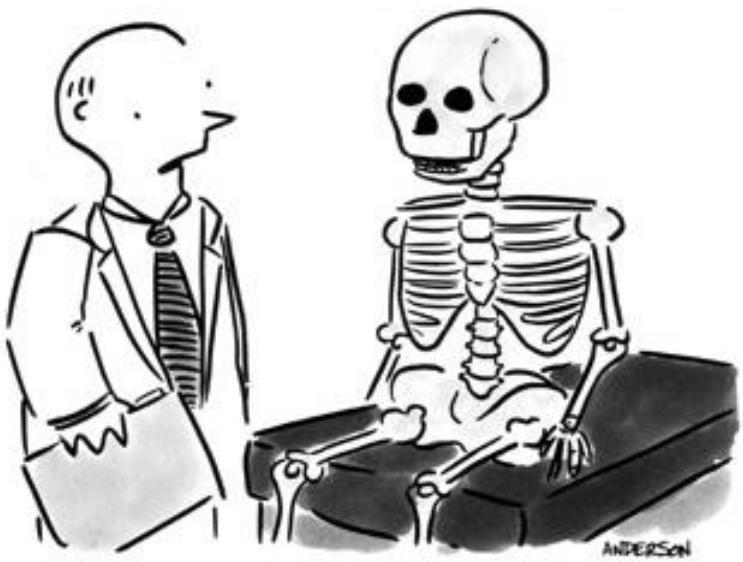
Source: UnitedHealth, *Farewell to Fee-for-Service: a real world strategy for health care payment reform* (December 2012)



"Still, let's do an x-ray just to be sure."

Health Care System Choices

Fragmentation	vs.	Coordination
• Multiple separate providers		• Accountable medical home
• Provider-centered care		• Patient-centered care
• Reimbursement rewards volume		• Reimbursement rewards value
• Lack of comparison data		• Price and quality transparency
• Outdated information technology		• Electronic information exchange
• No accountability		• Performance measures
• Institutional bias		• Continuum of care
• Separate government systems		• Medicare/Medicaid/Exchanges
• Complicated categorical eligibility		• Streamlined income eligibility
• Rapid cost growth		• Sustainable growth over time

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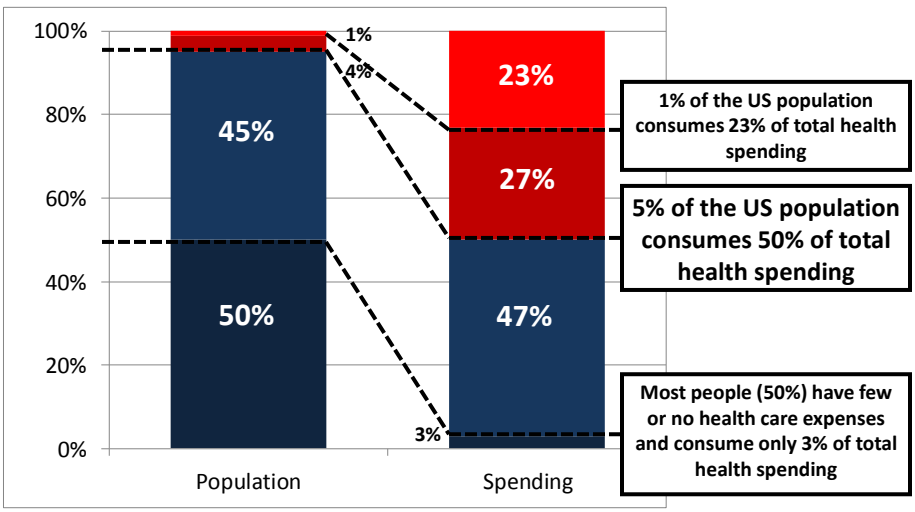
SOURCE: Adapted from Melanie Bella, *State Innovative Programs for Dual Eligibles*, NASMD (November 2009)

A few high-cost cases account for most health spending



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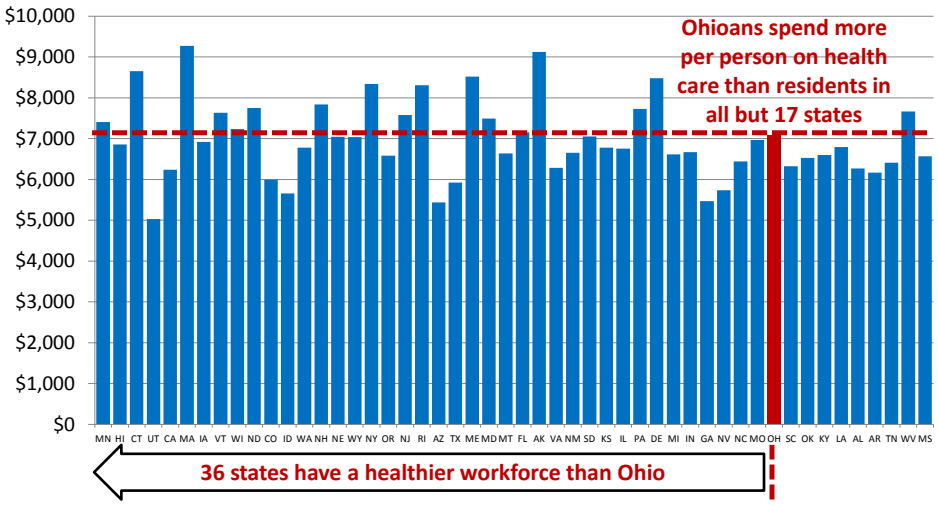
Source: Kaiser Family Foundation calculations using data from AHRQ Medical Expenditure Panel Survey (MEPS), 2007

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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2010 Affordable Care Act Changes

Included numerous provisions to enhance primary care:

- Primary care providers receive a 10% Medicare bonus
- Medicaid payment for primary care increase to 100% of Medicare
- Providers receive a one percentage point increase in federal matching payments for preventive services
- Expand coverage through Medicaid and subsidized exchanges
- "Essential health benefits" defined to include prevention, wellness, and chronic disease management
- Significant investments in patient-centered medical home (PCMH) pilots, workforce development, and prevention and wellness

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Source: Patient-Centered Primary Care Collaborative

Health Care Payment and Delivery System Trends

- Payer mix and provider networks changing as a result of ACA insurance mandates, Medicaid expansion, and new Exchanges
- New care and payment models will continue to develop and expand, and require scale and sophistication to implement
- Consolidation of providers will continue and accelerate, and health systems will continue to expand their continuum of care
- Physician shortage begins to take effect, ironically as the demand for enhanced primary care increases
- Data transparency will continue to increase and drive innovation, revealing "hot spots" as opportunities for better coordination

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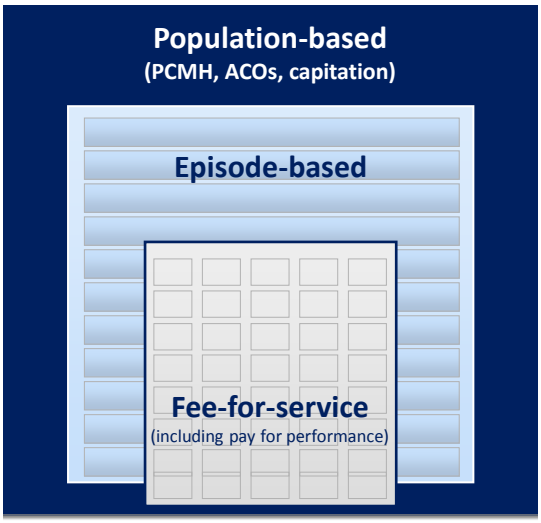
Shift to population-based and episode-based payment

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

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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 employers recognize the importance of health care innovation for the economy

Ohio health care purchasers represented on the Governor's Advisory Council on Health Care Payment Innovation:

COSE · Bob Evans · CardinalHealth · GE Aviation · P&G · PROGRESSIVE

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Why the Medical Home Works: A Framework

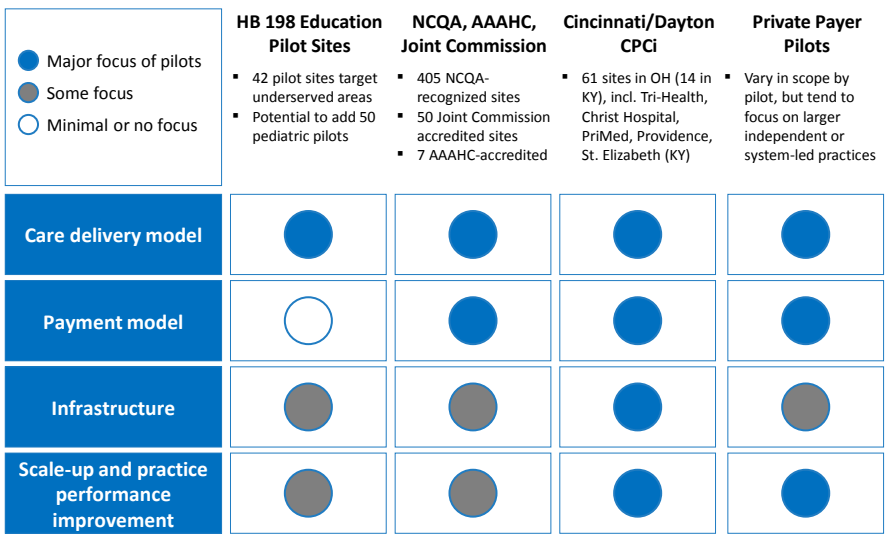
Feature	Definition	Sample Strategies
Patient-Centered	Supports patients and families to manage & organize their care and participate as fully informed partners in health system transformation at the practice, community, & policy levels	• Dedicated staff help patients navigate system and create care plans • Focus on strong, trusting relationships with physicians & care team, open communication about decisions and health status • Compassionate and culturally sensitive care
Comprehensive	A team of care providers is wholly accountable for patient's physical and mental health care needs – includes prevention and wellness, acute care, chronic care	• Care team focuses on 'whole person' and population health • Primary care could co-locate with behavioral or oral health, vision, OB/GYN, and pharmacy • Special attention is paid to chronic disease and complex patients
Coordinated	Ensures care is organized across all elements of broader health care system, including specialty care, hospitals, home health care, community services, & public health	• Care is documented and communicated effectively across providers and institutions, including patients, primary care, specialists, hospitals, home health, etc. • Communication and connectedness is enhanced by health information technology
Accessible	Delivers consumer-friendly services with shorter wait-times, extended hours, 24/7 electronic or telephone access, and strong communication through health IT innovations	• More efficient appointment systems offer same-day or 24/7 access to care team • Use of e-communications and telemedicine provide alternatives for face-to-face visits and allow for after hours care
Committed to quality and safety	Demonstrates commitment to quality improvement through use of health IT and other tools to ensure patients and families make informed decisions	• EHRs, clinical decision support, medication management improve treatment & diagnosis. • Clinicians/staff monitor quality improvement goals and use data to track populations and their quality and cost outcomes

Potential Impacts

- Patients are more likely to seek the right care, in the right place, and at the right time
- Patients are less likely to seek care from the emergency room or hospital, and delay or leave conditions untreated
- Providers are less likely to order duplicate tests, labs, or procedures
- Better management of chronic diseases and other illness improves health outcomes
- Focus on wellness and prevention reduces incidence / severity of chronic disease and illness
- Cost savings result from:
  - Appropriate use of medicine
  - Fewer avoidable ER visits, hospitalizations, & readmissions

Source: Patient-Centered Primary Care Collaborative (2014)

Ohio already has various PCMH projects underway



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Source: Ohio Patient-Centered Primary Care Collaborative , ODH; as of May. 2013.

Comprehensive Primary Care Initiative

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

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Source: www.innovations.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/Ohio-Kentucky

Regional Health Improvement Collaboratives

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5-Year Goal for Payment Innovation

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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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PCMH Payment Incentives

- Payers agree to provide resources to support business model transformation for a finite period of time, particularly for small, less capitalized practices
- Agree to provide resources to compensate PCMH for activities not fully covered by existing fee schedules (care coordination, non-traditional visits like telemedicine, population health)
- Agree to reward PCMHs for favorably affecting risk-adjusted total cost of care over time by offering bonus payments, shared savings, capitation, or sub-capitation.

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Source: Ohio PCMH Multi-Payer Charter (2013)

PCMH Care Delivery Improvements

- Risk-stratified care management (care plans, patient risk-stratification registry)
- Access and continuity of care (team-based care, multi-channel access, 24/7 access, same day appointments, electronic access)
- Planned care for chronic conditions and preventive care
- Patient and caregiver engagement (shared decision-making, more time discussing patient's conditions and treatment options)
- Coordination of care across the medical neighborhood (follow up on referrals, integrate behavioral and physical health needs, coordinate with all forms of insurance including BWC)

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Source: Ohio PCMH Multi-Payer Charter (2013)

PCMH Targeted Sources of Value

Initial focus is to reduce total cost of care and increase quality:

- Reduced inappropriate ED use and hospital admissions
- Reduced unnecessary readmits after an inpatient stay
- Appropriate use of Rx
- Improved adherence to treatment plan
- Recognition of high-value providers and settings of care

Over time, additional value will be accrued from:

- Low incidence of chronic illness
- Prevention and early detection from better screening, preventive care, etc.

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Source: Ohio PCMH Multi-Payer Charter (2013)

Benefits of Implementing a PCMH

PCMH	Fewer ED visits	Fewer Hospital Admissions	Cost savings
Alaska Medical Center	50%	53%	
Capital Health Plan, FL	37%		18% lower claims costs
Geisinger Health System, PA		25%	7% lower total spending
Group Health of Washington		15%	$15 million (2009-2010)
HealthPartners, MI	39%	40%	
Horizon BCBS, NJ		21%	
Maryland CareFirst BCBS			$40 million (2011)
Vermont Medicaid	31%		22% lower PMPM (2008-2010)

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Source: Patient-Centered Primary Care Collaborative, "Benefits of Implementing the PCMH: A Review of Cost and Quality Results (2012)

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 payers in state (including Medicare / Medicaid) to develop ability to support model at scale ▪ Influences state Medical school curriculums and related workforce initiatives

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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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

- **State Innovation Model (SIM) Test Grant Application**
- **Ohio Health Innovation Plan**
- **Multi-Payer PCMH Charter**